



A REPORT
TO THE
MONTANA
LEGISLATURE

FINANCIAL-COMPLIANCE AUDIT

*Department of Public
Health and Human
Services*

*For the Two Fiscal Years Ended
June 30, 2019*

APRIL 2020

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FINANCIAL-COMPLIANCE AUDITS

Financial-compliance audits are conducted by the Legislative Audit Division to determine if an agency's financial operations are properly conducted, the financial reports are presented fairly, and the agency has complied with applicable laws and regulations. In performing the audit work, the audit staff uses standards set forth by the American Institute of Certified Public Accountants and the United States Government Accountability Office. Financial-compliance audit staff members hold degrees with an emphasis in accounting. Most staff members hold Certified Public Accountant (CPA) certificates.

The Single Audit Act Amendments of 1996 and the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards require the auditor to issue certain financial, internal control, and compliance reports in addition to those reports required by *Government Auditing Standards*. This individual agency audit report is not intended to comply with these reporting requirements and is therefore not intended for distribution to federal grantor agencies. The Legislative Audit Division issues a statewide biennial Single Audit Report which complies with the above reporting requirements. The Single Audit Report for the two fiscal years ended June 30, 2017, was issued March 23, 2018. The Single Audit Report for the two fiscal years ended June 30, 2019, will be issued by March 31, 2020.

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April 2020

The Legislative Audit Committee
of the Montana State Legislature:

This is our financial-compliance audit report on the Department of Public Health and Human Services for the two fiscal years ended June 30, 2019. Included in this report are 27 recommendations related to improvements in internal controls and compliance with federal regulations, and errors in the financial records. Federal program recommendations include overarching policies and procedures as well as recommendations specific to nine of the federal programs administered by the department.

As shown in the department's written response to the audit recommendations, beginning on page C-1 of the audit report, the department concurs with eleven recommendations, partially concurs with seven recommendations, and does not concur with nine recommendations. In general, the department's written response focuses on its disagreement with our audit approach and/or conclusions, directs the reader's attention to information which is not relevant to the specific recommendation, and in some cases, indicates the department believes actions taken subsequent to the audit negate the findings contained in this report. The extent of disagreement indicates the department was not receptive to our communications and failed to respond to audit evidence which supports that multiple weaknesses in the design and operation of internal controls exist for programs administered by the department. As communicated in the audit report, in some cases these control weaknesses ultimately led to noncompliance with state and federal laws, regulations, and policies. In its response, the department did not provide any information which was not already considered as part of our audit. As such, we maintain our position as summarized in the audit report.

We thank the director and her staff for their cooperation and assistance throughout the audit.

Respectfully submitted,

/s/ Angus Maciver

Angus Maciver
Legislative Auditor

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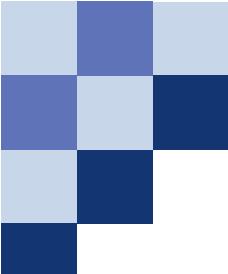
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APPOINTED AND ADMINISTRATIVE OFFICIALS

Department of Public Health and Human Services	Sheila Hogan, Director Laura Smith, Deputy Director Todd Harwell, Administrator, Public Health and Safety Division
Economic Services Branch	Laura Smith, Economic Security Services Branch Manager Chad Dexter, Administrator, Child Support Enforcement Division Marti Vining, Administrator, Child and Family Services Division Chanda Henmanson-Dudley, Administrator, Disability Employment Transitions Division Jamie Palagi, Administrator, Human and Community Services Division
Medicaid and Health Services Branch	Marie Matthews, Medicaid and Health Services Branch Manager Zoe Barnard, Administrator, Addictive and Mental Disorders Division Rebecca de Camara, Administrator, Development Services Division Darci Wiebe, Administrator, Health Resources Division Barb Smith, Administrator, Senior and Long-Term Care Division
Operations Services Branch	Erica Johnston, Operations Services Branch Manager Vacant, Administrator, Technology Services Division Carter Anderson, Administrator, Quality Assurance Division Kim Aiken, Administrator, Business and Financial Services Division

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MONTANA LEGISLATIVE AUDIT DIVISION

FINANCIAL-COMPLIANCE AUDIT

Department of Public Health and Human Services

For the Two Fiscal Years Ended June 30, 2019

APRIL 2020

19-14

REPORT SUMMARY

The Department of Public Health and Human Services (department) expended more than \$4 billion in state and federal funds for benefits and claims costs incurred during the audit period. Our audit identified nearly \$185 million in federal costs resulting from a violation or probable violation of federal regulation. These costs are defined in federal regulations as questioned costs. Some questioned costs are related to ongoing compliance issues related to centrally performed functions such as the allocation of costs benefitting more than one state or federal program. Other questioned costs stem from changes in department policy or weaknesses in the department's internal controls. Policy changes include eligibility verification processes which were first subject to review as part of this audit, as well as changes to a different kind of review of the department's service providers. Internal control weaknesses include breakdowns in communication or overall understanding where multiple divisions within the department are responsible for separate pieces of an overall process. As part of the state's Single Audit, federal grantor agencies may require the department to repay the questioned costs.

Context

The department is responsible for administering and supervising Montana's public assistance programs. The department's overarching goals are to provide for the health, safety, and self-sufficiency of all Montanans.

Department expenditures for the audit period included just over \$4 billion in federal funds. We audited 11 of approximately 120 federal programs administered by the department. These programs comprise over 95 percent of the federal expenditures, with Medicaid and the Supplemental Nutrition Assistance Program (SNAP) comprising approximately 82 percent of that total. Benefits and claims expenditures from all funding sources totaled over \$4.5 billion for the biennium, which is a \$500 million increase from the previous biennium. The increase is mostly the results of Medicaid which continued to climb in fiscal year 2018, and stabilized in fiscal year 2019.

The department contracts with service providers to process Medicaid claims and

SNAP benefits transactions. The department also manages over 100 information systems to handle eligibility, contractor payments, and other data intensive elements of its programs.

We audited the eleven department programs with federal expenditures ranging between \$2.1 million and \$2.9 billion for the two fiscal years ended June 30, 2019, as major federal programs. We performed tests to determine whether the department complied with certain federal regulations in administering those programs. Other testing included, but was not limited to, consideration of transactions related to personal services and benefits and claims. This included understanding the department's internal control policies and procedures, performing analytical procedures, and reviewing accounting transactions. We also reviewed and tested compliance with selected state laws and regulations.

(continued on back)

Results

The prior audit report contained 13 recommendations, of which the department implemented 6, partially implemented 2, and did not implement 5 recommendations. Recommendations not fully implemented are further discussed in this report.

This report includes 27 recommendations primarily related to improving internal controls and compliance with federal laws and regulations. The report also includes a recommendation related to the department's accounting for capital projects not completed by the end of a fiscal year. These incomplete capital projects are commonly called Construction Work in Process (CWIP). Errors in the department's CWIP accounting resulted in overstated assets totaling more than \$31 million at the end of each fiscal year 2018 and 2019.

We issued a qualified opinion on the department's financial schedules as a result of an omitted disclosure regarding benefit payments to ineligible individuals under the department's Medicaid and Children's Health Insurance Programs. Based on the results of our federal compliance testing, we estimate benefit payments to ineligible individuals to be \$84.1 million for the period under audit. The department disagrees with both our audit methodologies and our projection processes, which is further discussed in this report.

Recommendation Concurrence	
Concur	11
Partially Concur	7
Do Not Concur	9
Source: Agency audit response included in final report.	

Chapter I – Introduction

Audit Scope

We performed a financial-compliance audit of the Department of Public Health and Human Services (department) for the two fiscal years ended June 30, 2019. The objectives of the audit were to:

1. Determine whether the department complied with selected applicable state laws and federal regulations during the audit period.
2. Obtain an understanding of the department's control systems to the extent necessary to support our audit of the department's financial schedules and, if appropriate, make recommendations for improvements in management and internal controls of the department.
3. Determine the implementation status of prior audit recommendations.
4. Determine whether the department's financial schedules present fairly the results of operations and changes in fund equity for each of the fiscal years ended June 30, 2019, and 2018.

During the audit we focused our audit efforts primarily on the department's activity related to its federal programs. The department receives over \$1 billion dollars each year from the federal government, mainly related to public assistance programs. Many of these federal programs have requirements for the department to match a percentage of federal funds with state funds. Our audit efforts over the federal programs also included these state dollars. Other testing included, but was not limited to, transactions related to federal revenues, personal services, and benefits and claims. This included understanding the department's internal control policies and procedures, performing analytical procedures, and reviewing accounting transactions. We also reviewed and tested compliance with selected state laws and federal regulations.

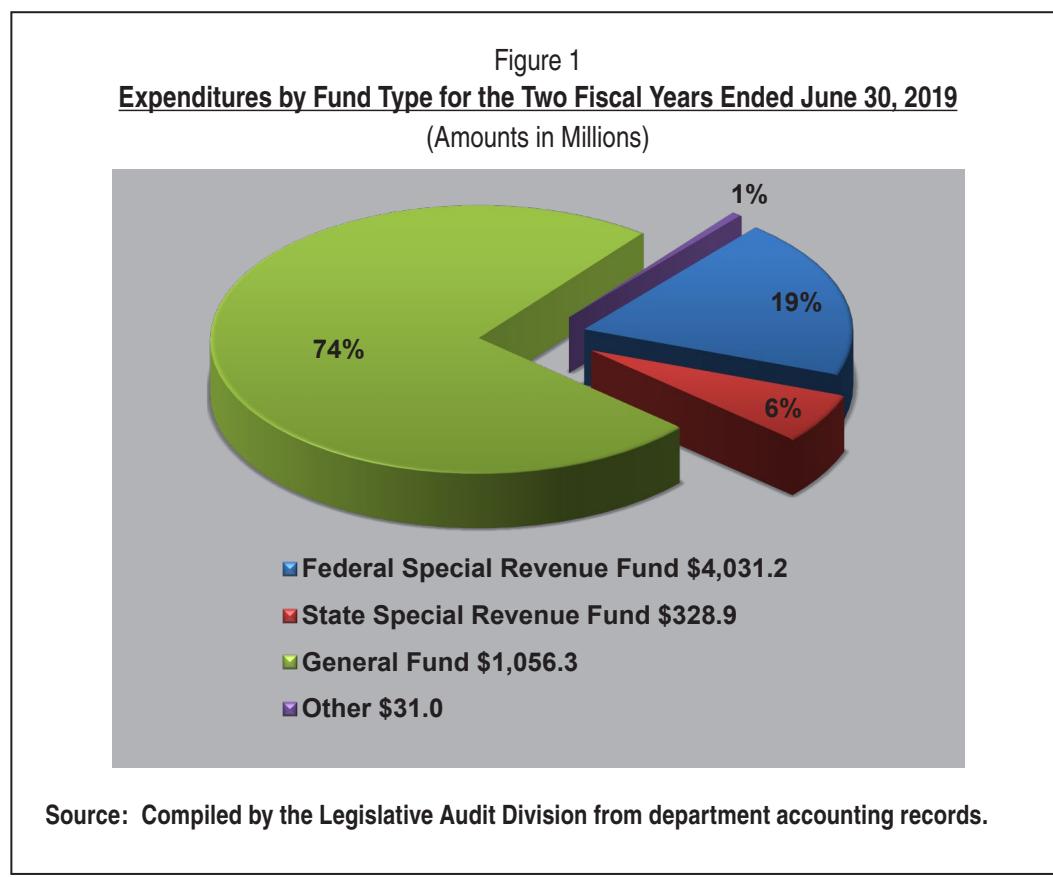
This report contains 27 recommendations to the department. These recommendations address areas where the department can improve internal controls and compliance with federal regulations and address errors in the accounting records.

Background

The department spent approximately \$2.75 billion in fiscal year 2018-19, and \$2.70 billion in fiscal year 2017-18, administering a wide spectrum of social service and health programs for the state of Montana. The programs include Medicaid, foster care and adoption, nursing home licensing, long-term care, aging services, alcohol and drug abuse, mental health services, vocational rehabilitation, disability services, child support enforcement activities, and public health services, including communicable disease control and preservation of public health through chronic disease prevention.

Department facilities, by location, include: Montana State Hospital, Warm Springs; Montana Mental Health Nursing Care Facility, Lewistown; Montana Chemical Dependency Center, Butte; Eastern Montana Veterans Home, Glendive; Montana Veterans Home, Columbia Falls; and Montana Developmental Center (MDC), Boulder. Chapter 258, Laws of 2017, extended the closure date for the MDC until June 30, 2019, and authorized the continued use of the Assessment and Stabilization Unit as a 12-bed secure intensive behavior center on the MDC campus. The department officially closed the MDC in October 2018, and its Intensive Behavior Center has been in operation since that time.

Total expenditures by fund for the two fiscal years ended June 30, 2019, are identified in Figure 1 below. Benefits and claims expenditures account for approximately 83 percent of the total expenditures.

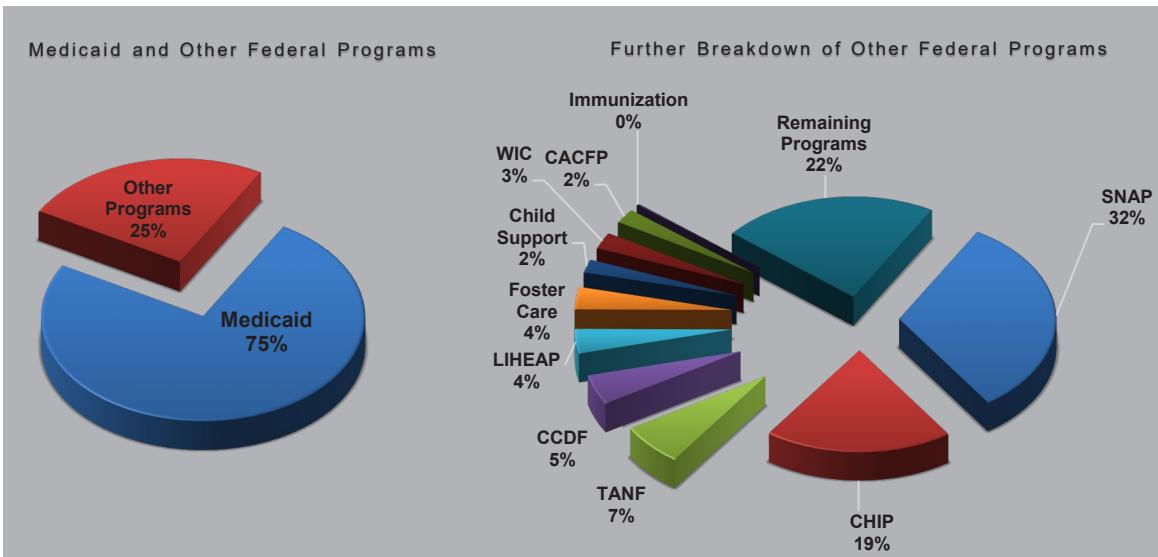


Federal regulations provide guidance to define major federal programs for the state of Montana subject to audit. Due to changes in federal regulations, only those major federal programs meeting specific risk criteria are audited.

We audited 11 department programs with federal expenditures ranging between \$2.2 million and \$2.9 billion for the two fiscal years ended June 30, 2019, as major

federal programs. We performed tests to determine whether the department complied with certain federal regulations in administering these programs. Figure 2 identifies the department's largest federal programs and the related expenditures recorded on the state's accounting records. Figure 2 also provides a comparison of Medicaid to all other federal program expenditures.

Figure 2
Breakdown of DPHHS Federal Program Expenditures
 For the Two Fiscal Years Ended June 30, 2019



Medicaid	\$2,987,325,155
Supplemental Nutrition Assistance Program (SNAP)	335,361,181
Children's Health Insurance Program (CHIP)	201,541,916
Temporary Assistance for Needy Family Program (TANF)	69,373,253
Child Care Development Fund (CCDF)	49,818,068
Low-Income Home Energy Assistance Program (LIHEAP)	40,864,038
Foster Care	37,318,019
Women, Infants, and Children (WIC)	27,366,630
Child and Adult Care Food Program (CACFP)	24,031,141
Child Support Enforcement	22,059,007
Immunization	2,194,909
Other Programs	233,961,642
Total	\$4,031,214,959

Source: Compiled by the Legislative Audit Division from department accounting records.

The Immunization program includes nonmonetary receipts from the federal government in the form of vaccines with an annual value of approximately \$10 million.

Medicaid Case Load

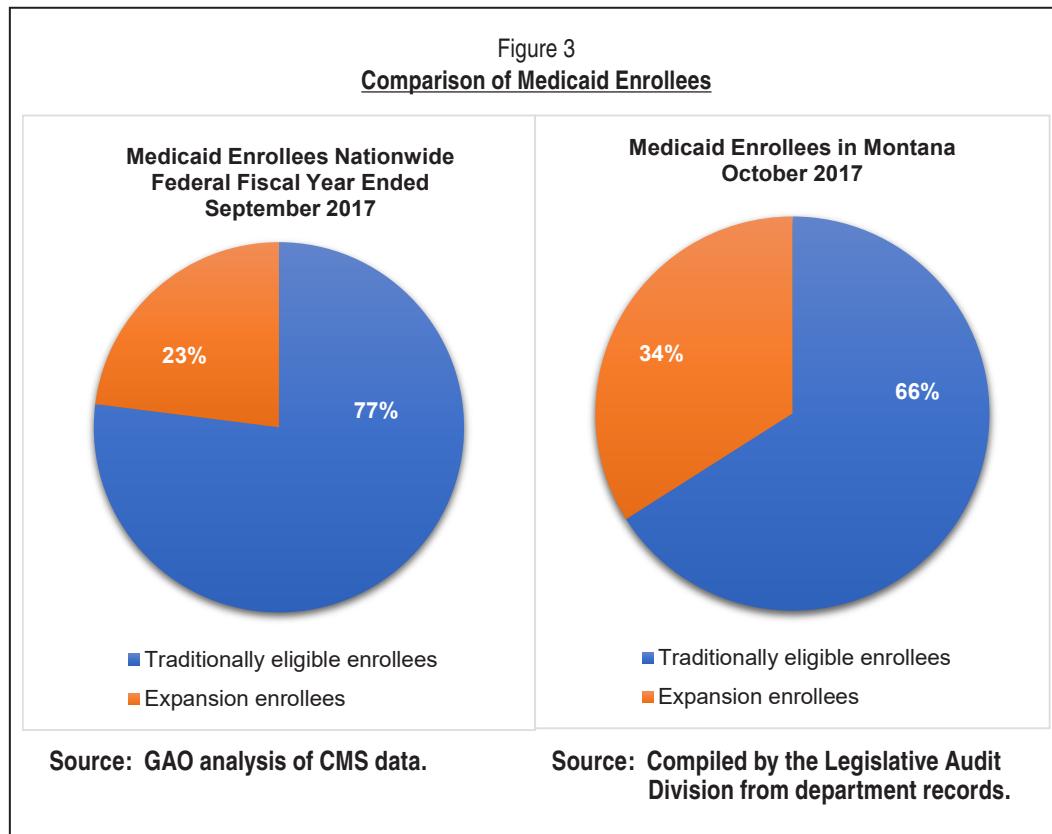
Over the course of the audit period, the number of Medicaid cases in Montana has begun to stabilize. As summarized in Table 1 below, Medicaid cases increased overall by nearly 19 percent between fiscal years 2017 and 2018, and subsequently decreased by approximately 3 percent between fiscal years 2018 and 2019.

Table 1
Department of Public Health and Human Services Case Load Analysis for Medicaid

	June 2017	June 2018	June 2019	Percent Change 2017 to 2018	Percent Change 2018 to 2019
Medicaid Title 19 (Physical health)- Unduplicated by case	205,855	233,070	225,358	13.22%	-3.31%
Medicaid Mental Health by case	16,329	16,462	15,680	0.81%	-4.75%
Medicaid Affordable Care Act (Physical health)-Unduplicated by case	69,042	95,254	92,183	37.97%	-3.22%
Medicaid Affordable Care Act Mental Health by case	6,688	9,288	9,381	38.88%	1.00%
Total Medicaid Cases	297,914	354,074	342,602	18.85%	-3.24%

Source: Compiled by the Legislative Audit Division from department records.

In comparison to nationwide data, Montana's Medicaid program has a higher percentage of individuals enrolled in Medicaid Expansion eligibility categories, as summarized in Figure 3 (see page 5).



In the figure above, traditionally eligible enrollees are eligible under historic Medicaid eligibility categories. ‘Expansion enrollees’ are individuals whose coverage began after their state opted to expand Medicaid as authorized by the Patient Protection and Affordable Care Act (ACA). The Nationwide data also includes in the ‘Expansion Enrollee’ category those individuals who were not traditionally eligible but were covered for Medicaid under a state-funded program as of December 2009 in states that subsequently opted to expand Medicaid under the ACA.

Organizational Structure

During the two years ended June 30, 2019, the department organization consisted of 3 branches and 12 divisions. Descriptions of the branches and divisions are provided below. The department’s organization chart and employee full-time equivalent (FTE) positions are shown in Figure 4 (see page 10). Due to statewide budget constraints, the department held certain positions vacant for a portion of the audit period. Where we believe FTE reduction is the cause related to a recommendation to the department, we have included that in the body of the report.

The **Director’s Office** (60.50 FTE) provides overall policy development and administrative guidance to the department. The Director’s Office staff includes legal

affairs, public information, human resources executive support, preventive resources center, planning, coordination and analysis, and health policy services.

The **Operations Services Branch** (260.83 FTE) includes the Office of Management & Fair Hearings (30.00 FTE) which provides impartial administrative hearings for individuals or entities who have received an adverse notice from the department. It also includes the following divisions:

- ◆ The **Business and Financial Services Division** (60.00 FTE) provides services for the department including financial and accounting oversight, department-wide budget monitoring and support, cash management, preparation and filing of federal financial reports, purchasing of supplies and equipment, audit coordination, lease management, mail handling, property and records management, accounts payable, and facility reimbursements.
- ◆ The **Quality Assurance Division** (104.23 FTE) monitors and ensures the integrity and cost effectiveness of programs administered by the department. Services include: oversight of health and day-care providers; investigation of allegations of fraud of recipient eligibility affecting Medicaid, Temporary Assistance for Needy Families, and Supplemental Nutrition Assistance Program; identification of parties responsible for paying client medical expenses; oversight of internal audits for department programs; and provide hearings for clients and providers participating in department programs.
- ◆ The **Technology Services Division (TSD)** (66.60 FTE) is responsible for the planning, implementation, and operations of information technology (IT) systems and infrastructure that directly support department programs. TSD develops a biennial DPHHS Information Technology Plan that establishes department goals and objectives regarding the development and use of IT and provides details on how the department will participate in meeting the goals of the State Strategic IT Plan. The division administrator, who also serves as the department's chief information officer, is responsible for implementing the plan and managing the work of the division.

The **Medicaid and Health Services Branch** (1,248.33 FTE) includes the Medicaid Systems Support Program (15.00 FTE) and the Medicaid & CHIP State Plan Amendment and Wavier Coordinator. It also includes the following divisions:

- ◆ The **Senior and Long-Term Care Division** (217.55 FTE) administers and provides publicly-funded, long-term care services for Montana's senior citizens and persons with physical disabilities through programs consisting of the Office on Aging, Medicaid community and nursing services, the state's two veterans' homes, protective services, and supplemental payments for Supplemental Security Income to eligible individuals residing in designated residential care facilities.
- ◆ The **Developmental Services Division** (206.91 FTE) provides services that help Montanans with disabilities to live, work, and fully participate in their communities. The division provides or contracts for institutional care, residential services, home-based services to families, case management,

children's mental health services, and a variety of employment outcome-related services. The division operates the Intensive Behavior Center in Boulder and administers the Developmental Disabilities Program.

- ◆ The **Addictive and Mental Disorders Division** (757.25 FTE) implements and improves a statewide system of prevention, treatment, care, and rehabilitation for Montanans with mental disorders or addictions to drugs or alcohol. The division achieves this by contracting for chemical dependency and adult mental health services with behavioral health providers. It also provides services in inpatient facilities at Montana State Hospital in Warm Springs, Montana Chemical Dependency Center in Butte, and Montana Mental Health Nursing Care Center in Lewistown. In addition, the Medicaid program funds outpatient and residential chemical dependency treatment for adolescents who are Medicaid recipients.
- ◆ The **Health Resources Division** (51.62 FTE) administers Medicaid primary care services, the Healthy Montana Kids Program, and Big Sky Rx, to improve and protect the health and safety of Montanans. The division reimburses private and public providers for a wide range of preventive, primary, and acute care services.

The **Economic Security Services Branch** (1,186.30 FTE) includes the following divisions:

- ◆ The **Human and Community Services Division** (488.30 FTE) supports the strengths of families and communities by promoting employment and providing the assistance necessary to help families and individuals meet basic needs and work their way out of poverty. The program provides cash assistance, employment training, Supplemental Nutritional Assistance Program, Medicaid eligibility determinations, early childhood care, energy assistance, weatherization, emergency shelter, and distribution of United States Department of Agriculture commodities.
- ◆ The **Child Support Enforcement Division** (140.31 FTE) obtains medical and financial support for children by establishing, enforcing, and collecting financial support owed by obligated parents. Services include locating absent parents, identifying assets, establishing paternity, and ensuring parents maintain medical health insurance coverage for their dependent children.
- ◆ The **Child and Family Services Division** (416.72 FTE) provides protective services to children who are abused, neglected, or abandoned. This includes receiving and investigating reports of child abuse and neglect, helping families to stay together or reunite, and finding placements in foster or adoptive homes.
- ◆ The **Disability Employment and Transitions Division** (140.97 FTE) operates programs to advance employment opportunities, independent living options, and transitions from high school to post-secondary education and work for Montanans with disabilities. The division offers services ranging from employment planning to transportation coordination and works with other agencies to reduce barriers for people with disabilities.

The **Public Health and Safety Division** (179.02 FTE) oversees the coordination of the public health system in Montana. The division provides a wide range of public health services to individuals and communities that are aimed at prevention of disease and promotion of health. Programs include clinical and environmental laboratory services; chronic and communicable disease prevention and control; maternal and public health services; public health emergency preparedness; Women, Infants and Child Special Nutrition Program; food and consumer safety; tobacco cessation and prevention program; and emergency medical services.

Total authorized FTE have decreased since the prior audit. Table 2 below compares authorized FTE above with FTE disclosed in our prior audit report.

Table 2
Changes in Full-Time Equivalent (FTE) Positions
Current and Prior Audit Periods

	FTE from #19-14 report	FTE from #17-14 report	Increase (Decrease) from Prior Audit
Director's Office	60.50	49.50	11.00
Operations Services Branch	260.83	248.83	12.00
Office of Fair Hearings	30.00	22.00	8.00
Business and Financial Services Division	60.00	60.00	0
Quality Assurance Division	104.23	104.23	0
Technology Services Division	66.60	62.60	4.00
Medicaid and Health Services Branch	1,248.33	1,287.40	(39.07)
Medicaid Systems Support Program	15.00	5.00	10.00
Senior and Long-Term Care Division	217.55	217.55	0
Developmental Services Division	206.91	295.17	(88.26)
Addictive and Mental Disorders Division	757.25	718.06	39.19
Health Resources Division	51.62	51.62	0
Economic Security Services Branch	1,186.30	1,168.24	18.06
Human and Community Services Division	488.30	488.31	(0.01)
Child Support Enforcement Division	140.31	157.31	(17.00)
Child and Family Services Division	416.72	381.65	35.07
Disability Services Division	140.97	140.97	0
Public Health and Safety Division	179.02	186.01	(6.99)
Total	2,934.98	2,939.98	(5.00)

Source: Compiled by Legislative Audit Division.

As shown in Table 2, FTE for Developmental Services Division and Child Enforcement Division have declined, mainly in response to the closure of the Montana Developmental Center in Boulder. For other functions such as the Director's Office, Medicaid Systems Support Program, and Child and Family Services Division, FTE have increased. Overall, department FTE is essentially unchanged from the previous audit. However, the department held certain positions vacant in response to statewide budget constraints experienced during the audit period. Throughout the report, we have indicated whether turnover or employee vacancies contributed to issues identified in the audit.

Prior Audit Recommendations

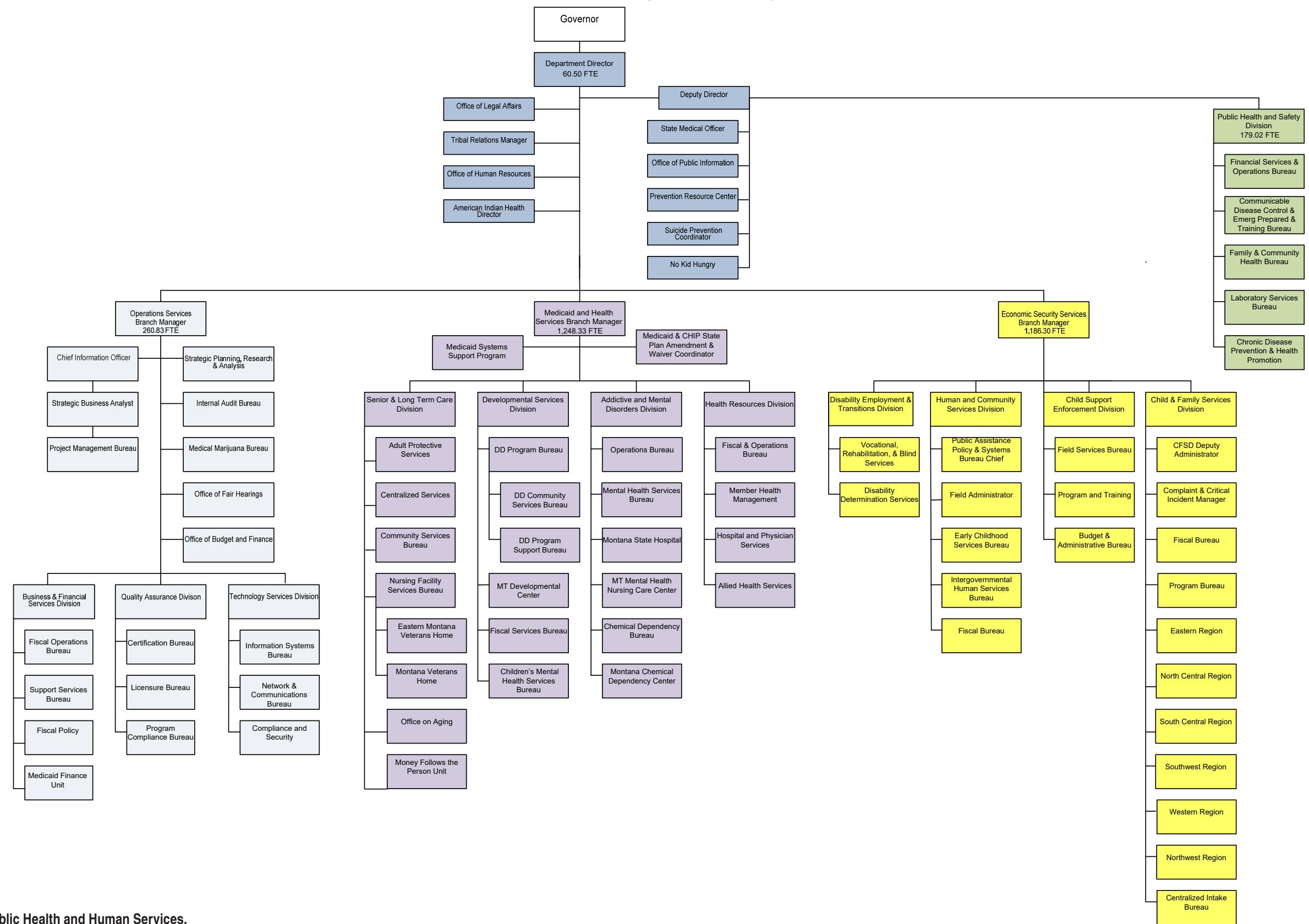
The prior audit report contained 13 recommendations. The department implemented 6 recommendations, partially implemented 2 recommendations, and did not implement 5 recommendations. Recommendations not fully implemented are discussed below and on pages 58 (Cost Allocation), 60 (Cash Management), 64 (ADP Monitoring), 41 (Income Eligibility and Verification System), 45 (Procurement for Services), and 56 (Recovery of Fraud Overpayments).

One of the prior audit recommendations not implemented was related to compensation of employees placed in administrative leave, which is further discussed below.

Wages for Staff on Administrative Leave

Our prior audit report included a recommendation that the department discontinue using federal Vocational Rehabilitation funds to pay the costs associated with staff placed on administrative leave. Payments for these staff continued through January and March 2018, when each employee respectively retired. Because the department did not discontinue payment, our recommendation is not implemented. We reviewed and did not identify other individuals in the Vocational Rehabilitation program on administrative leave for the period under audit. As such, we make no further recommendation at this time.

Figure 4
Department of Public Health and Human Services Organizational Chart by Bureau



Source: Department of Public Health and Human Services.

Chapter II – Findings and Recommendations

The Department of Public Health and Human Services (department) spent approximately \$2.03 billion in fiscal year 2019, and \$1.99 billion in fiscal year 2018, in federal funds administering a wide spectrum of social service and health programs for the state of Montana. Auditing standards, the Single Audit requirements, and certain methodologies applied in the course of our audit are discussed in further detail beginning on page 67.

Federal programs administered by the department include: Medicaid; Children's Health Insurance Program (CHIP); Foster Care; Child Support Enforcement; Supplemental Nutrition Services Program (SNAP); Temporary Assistance for Needy Families (TANF); Child Care Development Fund (CCDF); Low-Income Home Energy Assistance Program (LIHEAP); Child and Adult Food Care Program (CACFP); Supplemental Nutrition for Women, Infants, and Children (WIC); and Immunization Cooperative Agreements, which includes nearly \$10 million annually in vaccines rather than federal grant monies to the state. Most of the recommendations in this report are related to federal programs administered by the department. In total, we identified nearly \$185 million in costs resulting from violations or probable violations of a federal regulation. Federal Uniform Guidance defines these as questioned costs. Questioned costs identified by our audit are summarized in Table 3 (see page 12).

Table 3
Schedule of Questioned Costs by Federal Program
Fiscal Years 2018 and 2019

Federal Program	Topic	Recommendation #	Known Questioned Costs	Likely Questioned Costs
Medicaid	Eligibility	1	\$216,630	Between \$81,800,000 and \$152,000,000
	Cost Allocation	22	\$373,551	\$373,551*
Children's Health Insurance Program	Eligibility	1	\$362,303	Between \$2,264,338 and \$11,100,000
	Health Insurance Premium Payments	7	\$30,310	\$3,500,000
	Cost Allocation	22	\$29,745	\$29,745*
Supplemental Nutrition Assistance Program	Benefits	9	\$0	\$25,000*
	Cost Allocation	22	\$70,571	\$70,571*
Child Support Enforcement Program	Cost Allocation	22	\$67,509	\$67,509*
Foster Care	Cost Allocation	22	\$24,413	\$24,413*
	Training Costs	17	\$969,176	\$4,000,000*
Child Care Development Fund	Mandatory and Matching Funds	19	\$12,324,665	\$12,324,665
	Recovery of Fraud Overpayments	21	\$20,014	\$20,014
	Cost Allocation	22	\$109,909	\$109,909*
Temporary Assistance for Needy Families	Contracts for Services	15	\$805,539	\$805,539*
	Cost Allocation	22	\$48,960	\$48,960*
			Total Likely Questioned Costs	Between \$105,464,394 and \$184,500,056

Source: Compiled by the Legislative Audit Division.

*Indicates likely questioned costs could exceed amount shown.

Federal regulations require recipients of federal assistance to establish and maintain effective internal control to provide reasonable assurance the federal award is being administered in compliance with statutes, regulations, and the terms and conditions of the federal award. Internal controls are processes and procedures that provide management with reasonable assurance it will achieve its objectives related to compliance. Most recommendations address improvements needed in the department's internal controls for the federal programs it administers.

Medicaid and Children's Health Insurance Programs

As reported in our audit report on Medicaid Program Integrity (17P-02), the Patient Protection and Affordable Care Act (ACA), enacted in 2010, mandated many changes

to recipient eligibility policies and processes for Medicaid. The ACA replaced complex income-counting for determining financial eligibility with a more streamlined approach using Modified Adjusted Gross Income (MAGI), which is a standard that considers taxable income. Another significant change as a result of the ACA was moving away from in-person and documentation-reliant enrollment processes toward online applications and electronic data checks. Together, these changes moved much of the responsibility for demonstrating eligibility for the MAGI-based eligibility groups from individuals to the state. Related changes also standardized the rules for determining eligibility and providing benefits for the Children's Health Insurance Program (CHIP).

Non-MAGI-based eligibility determinations are applicable to coverage groups including the aged, blind, and disabled. MAGI-based eligibility determinations apply to most coverage groups which include individuals under age 65 in families with incomes below a certain Federal Poverty Level (FPL). The CHIP program provides services to uninsured, low-income children via the state's plan as well as through expanded Medicaid benefits. Medicaid and CHIP programs each require participants to have a social security number, to be residents of Montana, and to meet certain income and age criteria. Individuals who are blind, disabled, or those who received supplemental Social Security payments may qualify for the non-MAGI-based Medicaid services regardless of income. Under MAGI-based eligibility determination rules, an applicant's household and income are to be based from the individual's expected tax filer status (filer versus non-filer) and, for tax filers, from the individuals MAGI, as defined by the Internal Revenue Service (IRS). Federal poverty rates associated with income-based program eligibility requirements for household sizes of one to six individuals are summarized in the table below.

Table 4

2018 Federal Poverty Levels (FPL) Applicable to Medicaid and CHIP Eligibility Groups

Household Sizes Between 1 and 6 Individuals

Household Size:	Monthly FPL:	51%	56%	133%	138%	143%	261%
1	1,012	516	567	1,346	1,396	1,447	2,640
2	1,372	700	768	1,824	1,893	1,961	3,580
3	1,732	883	970	2,303	2,390	2,476	4,520
4	2,092	1,067	1,171	2,782	2,887	2,991	5,459
5	2,452	1,250	1,373	3,261	3,383	3,506	6,399
6	2,812	1,434	1,575	3,740	3,880	4,021	7,338

Source: Compiled by the Legislative Audit Division from department records.

Each FPL is associated with one or more Medicaid or CHIP eligibility groups. Information in Table 4 (see page 13) is useful when considering further details provided in sections below.

The changes for eligibility related to MAGI-based determinations for Medicaid and CHIP went into effect in Montana in January 2014, and were extended to new adult eligibility groups in January 2016. Due to ongoing federal pilot programs, federal guidelines excluded these changes from audit procedures until now. Consequently, this is the first federal compliance testing cycle in which our work has included MAGI-based eligibility determinations.

Department Eligibility Determinations

Each the Medicaid and CHIP programs have a State Plan which is approved by the federal Centers for Medicare and Medicaid Services (CMS). The department also has a combined Medicaid and CHIP MAGI-Based Eligibility Verification Plan (Verification Plan) which was filed with CMS.

The department uses the Combined Healthcare Information and Montana Eligibility System (CHIMES) to determine eligibility for Medicaid and CHIP applicants. Application information is either electronically uploaded or manually entered into CHIMES, which then determines client eligibility based on established business rules and eligibility requirements. Unless there are changes in CHIMES, an individual's eligibility for program benefits automatically rolls over to the next month.

For the period under audit, as permitted by federal regulations and documented in the state's Verification Plan, the department accepted self-attested information at enrollment for its MAGI-based coverage groups for the Medicaid and CHIP programs. Self-attested information must be verified via data matches with Social Security Administration and Montana Department of Labor and Industry wage information (external data sources) within 6 months of enrollment in order for eligibility to continue, and again after 12 months of enrollment. As discussed in the Income Eligibility and Verification System section beginning in Recommendation #12 below, twice per year the department is required to coordinate a data exchange with the IRS and use the information in making eligibility determinations for federal Health and Human Services programs including Medicaid, CHIP and the Temporary Assistance for Needy Families (TANF) programs. The data exchange with the IRS was only completed successfully one time during the audit period. During the period under audit, any information provided by the IRS was not considered by the department when making eligibility determinations and redeterminations.

Federal or state tax data was not used by the department to verify tax filer status, household size, or certain income. This means certain income types, including self-employment income, income from other states, and unearned income, were excluded from the department's eligibility verification process. During the audit period, the department did not have access to state tax data via a data match process; however, this did not preclude the department from accessing IRS tax data as is currently allowable under federal law. Neither did it preclude the department from requesting such data from the applicant when information from external data sources was not reasonably compatible with self-attested information.

Verification Plan Contrary to Federal Regulations

The department's choices under federal regulations allow ineligible individuals to receive benefits under the Medicaid and Children's Health Insurance programs.

Federal regulations specify, in part, "...except where the law requires other procedures..., the agency may accept attestation of information needed to determine the eligibility of an individual for Medicaid... without requiring further information from the individual." At its option, the department has chosen to apply different processes at application for individuals who preliminarily qualify for certain coverage groups under Medicaid as opposed to individuals who preliminarily qualify for the MAGI-based eligibility groups. For example, for non-MAGI-based Medicaid determinations the verification process takes place at application, while the verification process is delayed for applicants under MAGI-based Medicaid and CHIP determinations.

Federal regulations also specify the following:

- ◆ The department must promptly evaluate information received or obtained by it in accordance with regulations to determine whether such information may affect an individual's eligibility.
- ◆ If information provided by an individual is reasonably compatible with information obtained through required data matches, the department must determine or renew eligibility based on such information. Income information obtained through an electronic data match shall be considered reasonably compatible with information provided by the applicant/client if both are either above, at, or below the applicable income standard or income threshold for eligibility. Only in circumstances when information is not reasonably compatible can the department request additional information.

The department's Verification Plan quotes the federally required reasonable compatibility standard as discussed above. The Verification Plan also includes a 10 percent threshold for reasonable compatibility for income, which means the department only follows

up with the client when the information provided by external sources is higher than self-attested income by 10 percent or more. We considered whether the 10 percent threshold applied by the department could extend eligibility when a client does not meet the income criteria, and concluded the department's Verification Plan could lead to instances where external data indicates the client income exceeds the threshold for an eligibility group but the client is permitted to remain on the program without further department review. For example, an adult with a household size of three who self-reports monthly income of \$2,200 would qualify for Medicaid Expansion in the 133 percent FPL group. See Table 4 on page 13. If the external data source indicates the client's income is \$2,400, the department would not conduct follow-up because the difference in self-reported income and the external data source information is within the 10 percent threshold. However, a monthly income of \$2,400 would disqualify the adult from eligibility for all Medicaid Expansion groups. Additionally, the data matches are not designed to identify differences in reported versus actual household make-up or to confirm residency.

The design and implementation of the department's Verification Plan means Montana's Medicaid program has not complied with federal regulations regarding the use of information and requests of additional information for eligibility verification.

Internal Control Observations

Auditors' observations indicate internal controls over Medicaid and CHIP eligibility determinations are not designed to be effective.

During our audit design phase, we noted the department's internal control is not sufficiently designed to identify and remove participants from the Medicaid or CHIP programs when participants misrepresent their household composition, sources of income, and residency in order to circumvent the programs' eligibility requirements. We also observed situations where the department had evidence that a program participant was ineligible, but the department allowed them to remain in the program. Specifically, we observed evidence of the following internal control deficiencies over eligibility determinations:

- ◆ Instances in which the interfaces between information in the department's records with external data sources did not run.
- ◆ Instances when required redeterminations of eligibility did not occur.
- ◆ Instances where the department received evidence of discrepancies in eligibility criteria which were not followed up on.
- ◆ Instances where department staff overrode information system controls to allow ineligible individuals to remain in the Medicaid or CHIP programs.

As discussed above, the department has chosen to accept self-attested answers related to critical eligibility factors, including income and household size. Because we do not consider self-attestation to be factual without corroborating evidence, we do not consider the case files in CHIMES to contain facts supporting the eligibility determination, as required by federal regulations. Additionally, while federal eligibility regulations afford multiple options to the department, federal regulations clearly indicate, “Nothing in the regulations... should be construed as limiting the State’s program integrity measures or affecting the State’s obligation to ensure that only eligible individuals receive benefits.”

For these aforementioned reasons, we were unable to design reliable audit tests of department controls and instead planned to conduct more audit procedures to determine the department’s compliance with federal eligibility requirements, which included consideration of additional external data sources.

Compliance Testing

We planned for a statistical sample of 188 Medicaid and CHIP case files from a population of 571,862 unduplicated eligibility determinations for individuals from fiscal years 2018 and 2019. If an individual’s Medicaid or CHIP eligibility was stopped, or if an individual changed eligibility groups during the audit period, the individual may have been included in the population more than one time. Our sample was designed to achieve two objectives: 1) to affirm the reliability of information in the department’s eligibility records; and 2) to redetermine eligibility in accordance with requirements in the State Plans using additional sources of information. As discussed in the section beginning on page 67, we used state tax data as a factual information source for this work because tax information aligns with the underlying basis of MAGI-based determinations. Information included in state tax data is also relevant for non-MAGI-based determinations as further described in the next section.

After testing 63 case files which achieves the testing standard under federal Single Audits, we stopped testing due to the significant number of errors identified in our sample.

Tax Data Comparison

Client information in the CHIMES system is not consistent with state tax data.

For each sample item, we performed a comparison of Medicaid and CHIP key eligibility factors between the department’s case file information and state tax data. We considered the following eligibility factors:

- ◆ **Household Size:** For the MAGI-based groups, the use of tax filer status is critical because it drives whether the department should use CMS “tax filer rules” or “non-tax filer rules” to determine household size. Household size is critical because it sets the allowable income level for both MAGI-based and non-MAGI-based applicants.
- ◆ **Income:** For MAGI-based groups, MAGI information available on tax records is the basis for income eligibility determinations. As mentioned above, while certain individuals may qualify for Medicaid regardless of income, for some non-MAGI-based eligibility categories, income remains a key eligibility factor.
- ◆ **Residency:** In order to qualify for Montana’s Medicaid or CHIP programs, an individual must reside within the state’s boundaries. State tax data includes evidence which supports state residency status.

Table 5 below shows the results of our sample testing for these three key eligibility factors and indicates whether or not we found the department’s case file information to be supported, or whether there was no state tax data available.

Outcome	Key Eligibility Factors		
	Household Factor	Income Factor	Residency Factor
Case File Information Supported	44	26	53
Case File Information Not Supported	6	25	5
No State Tax Data Available	13	12	5
Total	63	63	63

Source: Compiled by the Legislative Audit Division from sample results.

As illustrated in the above table, we concluded information in CHIMES for key eligibility factors is not supported by state tax data.

Indications of Ineligibility

We found a significant number of clients who may not meet eligibility criteria for the Medicaid and Children’s Health Insurance programs.

Using all data gathered in our sample, we considered whether the eligibility determination made by the department was appropriate. In some cases, all individual eligibility factors were affirmed using state tax data (as discussed in the previous section); however, the eligibility determination made by the department was not consistent with eligibility criteria in the CMS-approved State Plan when state tax data

was also considered. The table below highlights 10 examples of the 26 sample errors identified in our work.

Table 6 Examples of Errors Identified in the Auditor's Redetermination of Medicaid and CHIP Eligibility				
	CHIMES Information	State Tax Data	Indication of Ineligibility Identified by Audit	Additional Context
Indication Based on Household Size				
Client A	One adult	One adult; one dependent	Potentially Not Eligible	Department case notes lack clarity for household composition making it impossible for the auditor to redetermine eligibility.
Indication Based on Income				
Client B	\$3,991 monthly	\$6,091 monthly	Wrong Group	Department redetermination not timely; dependent placed in Medicaid funded CHIP group, but qualifies for eligibility group funded by CHIP.
Client C	\$3,456 monthly	\$4,270 monthly	Wrong Group	Dependent placed in Medicaid funded CHIP group, but qualified for eligibility group funded by CHIP.
Client D	\$1,090 monthly	\$5,375 monthly	Not Eligible	Department redetermination not timely; dependent is not eligible based on income but is receiving MAGI-based Medicaid benefits.
Client E	\$2,240 monthly	\$2,641 monthly	Not Eligible	Income exceeds all eligibility limits for a household size of 3 for adult Medicaid coverage.
Client F	\$0 monthly	\$709 monthly	Wrong Group	CHIMES system has evidence of client income, but \$0 income was copied forward at the eligibility redetermination date. Client received MAGI-based Medicaid benefits without paying the associated premium for the eligibility group for which he qualified.
Client G	\$0 monthly	\$2,863 monthly	Not Eligible	Client aged out of CHIP group and was placed in MAGI-based Medicaid group for continuous eligibility without considering client's income.
Indication Based on Residency				
Client H	\$0 monthly	No Tax Data	Not Eligible	Department received returned mail three times in calendar year 2017, and an additional three times in calendar year 2019. Department records indicate a Florida address was identified in February 2019. Dependent remained eligible for CHIP benefits for first 20 months of the audit period.
Other Indications of Ineligibility				
Client I	Client turns 19 years old	N/A	Not Eligible	Department controls did not stop benefit payments when child aged out of Medicaid funded CHIP program.
Client J	Client placed in Foster Care	N/A	Wrong Group	Child is receiving benefits in incorrect eligibility group for MAGI-based Medicaid.

Source: Compiled by the Legislative Audit Division.

The examples in Table 6 (see page 19) were selected to illustrate an important issue regarding our testing. Even when we found evidence in state tax data indicating a circumstance that could be an error under federal regulations, this does not necessarily mean the client should have been identified as categorically ineligible for coverage under any Medicaid enrollment category. A significant proportion of the sample errors we identified resulted in a client being placed in the wrong enrollment category. As shown in the table, we also found additional errors that were not identified as a result of comparisons with state tax data, but were the results of internal control deficiencies or other errors on the part of the department. The table below summarizes the results of our testing by a greater level of detail regarding key eligibility factors and overall eligibility redetermination results.

Table 7
Auditor Eligibility Redetermination Results for Medicaid and CHIP
Fiscal Years 2018 and 2019

Department's Eligibility Determination Supported	21
Department's Eligibility Determination Not Supported:	
Incorrect Eligibility Category	9
Not Eligible Due to Income Limit	16
Not Eligible Due to Residency Requirement	1
No State Tax Data Available	16
Total	63

Source: Compiled by the Legislative Audit Division from sample results.

It is important to understand what these sample results do and do not mean. Our sampling was not designed to produce a precise estimate of the rate of error in the department's eligibility determinations. Neither was it designed to replicate the kinds of payment error estimation methodologies the federal government uses to assess state's program integrity efforts. It was designed to determine whether clients receiving Medicaid and CHIP benefits meet eligibility requirements for specific eligibility groups, as outlined in the State Plan. Therefore, although these sample results should not be used to project error occurrence rates for the state's Medicaid and CHIP programs as a whole or for specific enrollment categories, it is entirely appropriate the results form a basis for reporting questioned costs as required under the Federal Single Audit Act and associated regulations.

Questioned Costs

Sample results have identified questioned costs for the Medicaid and Children's Health Insurance programs.

To be allowable costs of the federal programs, the individual receiving medical services must be eligible at the time of service. If a Medicaid or CHIP client received services but was not eligible at the time of service, the associated costs are unallowed and considered questioned costs for the affected program. Questioned costs means a cost questioned by the auditor because of an audit finding which resulted from a violation or possible violation of regulation of a federal award, where costs are not supported by adequate documentation, or where costs incurred appear unreasonable and do not reflect the actions a prudent person would take in the circumstances.

Known Questioned Costs

Based on the results of our redeterminations of eligibility, as described beginning on page 18 and summarized in Table 6 (see page 19), 26 department determinations are not supported. Of those, 17 case files had indications of ineligibility for all Medicaid and CHIP eligibility groups mainly due to individuals having income in excess of the allowable FPL included in the State Plan. For the remaining 9 cases, the department placed the individual into an incorrect eligibility group. Because benefit payments associated with these individuals do not meet the allowable cost criteria described on page 18, department payments on behalf of these individuals are questioned costs. In total, we question \$216,630 in benefit payments for these individuals.

For the remaining 16 cases where no tax data was available, the department's records do not demonstrate that the information used to make the eligibility determination is factual. Therefore, additional benefit payments totaling \$362,303 made on behalf of these individuals are considered questioned costs.

Likely Questioned Costs

Results of our testing demonstrate that indications of ineligibility in the CHIP and Medicaid populations is isolated to MAGI-based eligibility groups. We found no evidence to indicate errors in department determinations for non-MAGI groups. Assuming the same rate of ineligibility in the entire population of Medicaid and CHIP participants where state tax data is available, we projected questioned costs using the average annual claims for each eligibility group. Due to error isolation in the MAGI-based eligibility groups, we factored in a three-month time period to account for the time prior to department verification procedures. Using this methodology, we

project likely federal questioned costs for the CHIP program are \$1.1 million annually, and \$41.3 million and \$40.5 million for Medicaid in fiscal years 2018 and 2019, respectively.

The Federal Single Audit Act affords federal grantor agencies considerable authority regarding repayment of disallowed costs. In addition, recent pronouncements and actions by CMS suggest a renewed focus on program integrity at the state and federal levels may result in changes in how the federal agency approaches compliance issues. Given these developments, assuming repayment of questioned costs is improbable would not be prudent. As such, we believe as of June 30, 2019, a \$84.1 million contingency for the state's General Fund exists.

Summary

Auditor redeterminations are reasonably consistent with the department's review.

Department staff disagree with both our audit scope for testing eligibility and our methodology used to project questioned costs. However, the department conducted its own review of eligibility determinations included in our sample. As described above, eligibility automatically rolls over to the next month unless CHIMES determinations are updated. The department reviewed the 1,512 'member months' associated with our 63 sample items. Based on results of its review, the department acknowledges a 5.8 percent error rate at the 'member month' eligibility level in the population tested in our sample. The department also determined a total of \$13,546 in medical claims associated with the months when eligibility determinations were not supported. We estimate the department's 5.8 percent error rate in eligibility could equate to as much as \$99.2 million and \$98.9 million in inappropriate benefit payments for the CHIP and Medicaid programs, in total, for fiscal years 2018 and 2019, respectively, when projected to the population as a whole.

Payment Error Rate Measurement (PERM) Program

Likely questioned costs are consistent with national improper payment rates.

The federal PERM program is utilized to calculate national improper payments for Medicaid and CHIP. Annually, the PERM program measures the national Medicaid and CHIP improper payment rates and uses a 17-state three-year rotation process. Each state is reviewed once every three years. The national improper payment rates include findings from the most recent three measurement cycles, so all states are captured in one rate. The national improper payment rates are comprised of three components:

fee-for-service, managed care, and eligibility. Improper payments related to eligibility have been excluded from the federal PERM evaluations since 2014, or since passage of the ACA. The only remaining PERM component applicable to Montana is the fee-for-service improper payment rate. As demonstrated in Table 8 below, while Montana's PERM rate is traditionally lower than the national average, the PERM rates overall have increased significantly since passage of ACA. Additionally, as PERM rates once again begin to incorporate the eligibility component, we expect the PERM rates will be even higher.

Table 8 National and Montana Fee for Service (FFS) PERM Rates 2014 and 2017 PERM Reviews		
	2014 Rate	2017 Rate
National FFS PERM Rate	10.59%	14.31%
Montana FFS PERM Rate	5.8%	*

Source: Compiled by Legislative Audit Division from CMS reports.

* CMS did not release state-specific rates for 2017.

Conclusion

Overall, the results of our testing indicate individuals who did not meet eligibility criteria outlined in the State Plan received Medicaid or CHIP benefits during the audit period.

The department is taking steps to change the eligibility process, as the 2019 Montana Legislature passed revisions to state law which require the department to verify eligibility using allowed data sources at application. Changes to state law also provide the department access to state taxpayer return information for purposes of verifying the income reported by applicants for medical assistance. Because these legislative changes address many of the circumstances discussed in this report, we do not recommend any changes specific to state law, but because these changes will affect our next federal compliance testing cycle (fiscal years 2020 and 2021), we will have an opportunity to monitor how the department implements these new provisions.

RECOMMENDATION #1

We recommend the Department of Public Health and Human Services, as it relates to the Children's Health Insurance Program and Medicaid federal programs:

- A. *Revise its Verification Plan to require additional information from the client when income information received from external data sources exceeds the limitation for the client's preliminarily authorized eligibility group, as required by federal regulations.*
- B. *Revise its policies and procedures, including any necessary revisions in the State Plan, to ensure only eligible individuals receive benefits, as required by federal regulations.*
- C. *Establish and maintain internal controls to timely verify client eligibility factors for all applicants and clients at application and redetermination.*
- D. *Comply with federal regulations and state plan requirements by placing only eligible clients into correct eligibility categories.*

Medicaid

During the audit, we identified additional improvements in internal control and compliance with federal and state regulations applicable to the Medicaid program, as discussed in the following four sections.

Third Party Liability Identification

During the audit period, the department did not conduct State Wage Information Collection Agency (SWICA) and Social Security Administration (SSA) wage and earnings file data matches upon application for individuals seeking Medicaid coverage via the MAGI-based determination process. There is no amendment or waiver to Montana's Medicaid plan allowing these data matches or follow-up to be delayed for MAGI-based applications.

Montana's Medicaid State Plan requires the department to complete the SWICA and SSA matches upon application to the Medicaid program to identify the employers of the applicant for purposes of identifying the legal liability of potential third parties for medical claims. Federal regulations require follow-up to occur within 45 days. Instead, for its MAGI-based applicants, the department follows its verification plan which indicates these same data matches are conducted within 90 days of application. However, there is no amendment or waiver to the state plan allowing these data matches or follow-up to be delayed for MAGI-based applicants.

By delaying the data matches for MAGI-based applicants, the department has not complied with requirements in the state plan to identify potential third parties at application. Further, risk exists that costs of medical services for the MAGI-based determined population are being paid with Medicaid program funds prior to exhausting the third-party resources, which is also contrary to federal regulations.

RECOMMENDATION #2

We recommend the Department of Public Health and Human Services conduct the State Wage Information Collection Agency and Social Security Administration data matches to identify potential liable third parties at application for all Medicaid applicants, as required by the State of Montana Medicaid Plan.

Fraud Investigations

Federal regulations require the department to protect the integrity of Montana Medicaid from fraud, waste, and abuse from both providers and beneficiaries.

The Surveillance Utilization Review Section (SURS) performs retrospective reviews of paid claims, recovers identified overpayments, and educates medical providers. If the findings of a preliminary SURS investigation give the department reason to believe an incident of fraud or abuse by a Medicaid provider has occurred, federal regulations require referral of suspected fraud to the Medicaid Fraud Control Unit (MFCU) at the Montana Department of Justice for further investigation.

The Program Integrity Unit is responsible for investigating any case of alleged fraud and abuse by Medicaid beneficiaries. If there is reason to believe that a beneficiary has defrauded the Medicaid program, the department must refer the case to law enforcement. If there is reason to believe that a beneficiary has abused the Medicaid program, the department must conduct a full investigation for abuse.

Recommendations #3 and #4 below discuss recommended improvements in internal control and compliance over Medicaid fraud investigations.

Provider Fraud

The department did not maintain adequate documentation of investigations of Medicaid providers, as required by federal regulations.

The SURS unit closed 692 investigations during the audit period. From this list, we selected a sample of 40 closed case files. We reviewed the case file documentation for the 37 files provided and considered whether the department followed its guidelines which specify the basis for making referral to the MFCU. The department was unable to locate case files for the remaining three cases selected in our sample. For 1 of the 37 cases reviewed, the documentation in the case file was incomplete.

Absent complete documentation, the SURS unit decision on whether or not to make a referral is not supported. The department recognized its focus on new provider reviews required modification. Department management indicates quality improvement controls for record keeping were implemented by the SURS unit in May 2019. Additionally, the department claims it has improved new employee training to focus on record keeping and has implemented internal reviews of new employee case files for completeness for a period of at least the first six months of employment.

During the period under audit, new provider reviews made up over half of all SURS provider investigations. Focusing on new provider reviews limits the department's ability to identify potentially fraudulent or abusive billing practices by more established providers which make up a larger percentage of overall Medicaid claims and payments. Additionally, Chapter 82, Laws of 2017 Regular Session, established restrictions on overpayment audits including limiting records requests to a six-month period within three previous years, restricting follow-up audits to the same billing codes associated with the initial audit, requiring audits be completed in 90 days, and prohibiting projection of overpayments identified in the sample to a larger set of claims. Without changes in department policy and state law, the department's ability to identify and fully investigate for provider fraud are hindered. During the 2019 Legislative Session, and in response to our performance audit (17P-02), Senate Bill 235 from the 2019 Legislative Session proposed such changes, but the bill failed.

RECOMMENDATION #3

We recommend the Department of Public Health and Human Services:

- A. *Establish and maintain internal control to ensure the Surveillance Utilization Review Section investigations for provider fraud are completely documented and retained.*
- B. *Implement changes in department policy and seek changes in legislation to remove restrictions on provider overpayment audits.*

Beneficiary Fraud

Internal controls to investigate referrals for Medicaid beneficiary fraud and abuse are not designed to ensure full investigations are conducted and referrals to law enforcement occur, as required by federal regulation.

During the audit, we reviewed the department's policies and procedures for investigations of Medicaid beneficiary fraud. Per department policy, Program Integrity Unit staff are directed to stop their investigation if fraud is not identified within the first 20 minutes of initial investigation. This does not allow for full investigation of fraud allegations, as required by federal regulation. Additionally, department policy limits referrals of beneficiary fraud to law enforcement only if the established overpayment amount exceeds \$10,000, whereas federal regulation requires all instances where beneficiary fraud is reasonably possible be referred to law enforcement. Absent the ability to conduct full investigations or to make complete referrals to law enforcement, the department is unable to demonstrate compliance with federal regulations.

Department management indicated the policy was put into place in October 2018 as a time-management tool to assist staff in addressing a backlog of referrals. Department management reported the policy limitations were removed in September 2019.

RECOMMENDATION #4

We recommend the Department of Public Health and Human Services:

- A. *Update policies and procedures for Medicaid beneficiary fraud investigations to require full investigations by department staff.*
- B. *Make referrals to law enforcement when there is reason to believe a beneficiary has defrauded the program, as required by federal regulations.*

Suspending Participation

A legal interpretation by department staff did not allow for compliance with state law during the audit period.

Section 45-6-313, MCA, requires a person convicted of the offense of Medicaid fraud be suspended from participation in Montana's Medicaid program for specified minimum time periods for the first, second, and third offense. Department staff interprets the 14th amendment to the United States Constitution, which establishes governmental power, as criteria which prevents suspension of individuals from receiving Medicaid benefits. Specifically, department staff cited section 1 of the 14th amendment, which states in part, "No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States..." We disagree with this legal interpretation because federal regulations specifically permit the state to limit, restrict, or suspend the eligibility of an individual convicted of crimes involving federal health care programs.

While department management believes it complies with the state law, department management also admits it has not developed a mechanism to identify individuals convicted of Medicaid fraud. However, without a process to identify these individuals, the department is unable to comply with the statutory requirement. Department management plans to work with stakeholders in the Judiciary and in state and federal prosecution services to implement a system for reporting convictions to the state Medicaid agency. Department management believes creation of such a system may require legislative action.

RECOMMENDATION #5

We recommend the Department of Public Health and Human Services:

- A. *Develop a system to receive notification of individuals convicted of Medicaid fraud.*
- B. *Suspend individuals convicted of Medicaid fraud from receiving benefits for minimum time periods required by state law.*

Medicaid Contract Disclosures

The department did not include the required language related to debarment and suspension in a contract for premium billing and collections services for the Medicaid program, and department internal controls did not identify or prevent the omission.

In an effort to modernize its Medicaid systems, the department is replacing its Medicaid Management Information System (MMIS). The replacement project is referred to as Montana's Program for Automating and Transforming Healthcare (MPATH), with total estimated costs of \$146 million for state fiscal years 2019 through 2021. As part of the audit, we obtained and reviewed four contracts related to this effort. We identified one contract in which the required language related to debarment and suspension was not included.

Federal regulations require all contracts made by a nonfederal entity under the federal award must contain provisions, including the provision that the award must not be made to parties debarred or suspended from participation in federal award programs. Department staff indicate the contractor was informed of the federal debarment requirements during the contracting process, but the contract attachment relevant to suspension and debarment was inadvertently excluded from the final contract submitted to and signed by the contractor. Department management provided the purchase order for the entity that bills and receives payments for these services. While the purchase order contains the suspension and debarment language, we do not consider this to be a certification by the entity because the purchase order is not signed by the entity. As a result, the department has not complied with federal regulations related to required contract language for its Medicaid program. While the four contractors were not on the federal suspended and debarred parties list, without adequate controls there is risk that the department will contract with a suspended or debarred party.

RECOMMENDATION #6

We recommend the Department of Public Health and Human Services:

- A. *Establish and document internal controls to ensure all relevant contract disclosures and attachments are included in the Medicaid contract agreement prior to signature.*
- B. *Comply with federal regulations by including all applicable and required language in Medicaid contracts with nonfederal entities.*

Children's Health Insurance Program (CHIP)

In addition to Recommendation #1, which applies to the CHIP program, our audit identified the following improvement regarding allowed costs for CHIP.

Health Insurance Premium Payments

Federal regulations permit one Medicaid eligibility group to receive CHIP funded health insurance premium payments. Department controls did not prevent other eligibility groups from receiving CHIP-funded health insurance premium payments during the period under audit.

Through its state plan, the department offers CHIP-funded Medicaid benefits for children 6 to 18 years of age whose family income is between 101 percent and 143 percent of the federal poverty level. Because this group is covered by Medicaid, recipients may be members of the department's Health Insurance Premium Payment (HIPP) program if the department determines it to be cost-effective. Under the HIPP program, the department uses federal program dollars to pay the premiums for health insurance coverage for other insurance policies. Appropriate federal funds used for HIPP depend on the individual's eligibility for either the Medicaid or CHIP programs.

When conducting a sample of CHIP benefit payments, we identified a portion of the transactions were health insurance premium payments. Because we did not expect this activity in our sample population, we isolated the HIPP transactions totaling \$5.5 million to conduct a separate audit test. We selected and reviewed 11 of the 7,762 transactions for health insurance premiums. Our review identified seven instances where the department should have used Medicaid funds instead of CHIP funds to pay the third-party health insurance premiums. These payments totaling \$30,310 are not an allowable use of CHIP funds, and are considered questioned costs. Using the error rate based on the transactions reviewed, total projected questioned costs are \$3.5 million for the period under audit.

Department officials indicate the unallowable payments resulted from a lack of internal controls to ensure that charging mechanisms in the state's accounting system used by one division in the administration of HIPP payments were accurate and current. Additionally, department officials indicated the costs are allocated to a different department division whose staff is not aware of the specific details of the HIPP program, and is therefore unable to review the financial activity for accuracy.

RECOMMENDATION #7

We recommend the Department of Public Health and Human Services:

- A. *Develop internal control procedures to ensure the appropriate funding source is used for its Health Insurance Premium Payment program.*
- B. *Use federal Children's Health Insurance Program funds to pay third-party health insurance premiums only for those individuals who qualify, as required by federal regulations.*

Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and Special Supplemental Nutrition Program- Women, Infants and Children (WIC) Programs

The department uses the same information system to administer portions of its Medicaid, CHIP, SNAP and TANF programs. Additionally, the department uses the same service organization for portions of the SNAP, TANF, and WIC federal programs. The following seven recommendations discuss improvements mainly related to the SNAP and TANF programs.

Information Systems

The department uses a multitude of information systems to administer its federal and state programs and to conduct its business. Some information systems are owned and operated by the department, while others are used under contract with various organizations (known as service organizations) which provide transaction processing and data related services. While the department may choose to contract certain data processing and program functions to a service organization, it cannot contract away its responsibility to establish and maintain adequate internal control over its business operations. A common method to ensure a service organization is achieving its obligations is to obtain an examination of the controls and processes of the service organization. These examinations must be conducted by an independent auditor. This generally occurs by contracting with a certified public accountant who conducts the examination and discusses the results of which are accumulated into a System and Organization Controls (SOC) report. A SOC examination can be structured in various ways to meet the needs of intended users of information included in the SOC report. The following table outlines two types of SOC examinations.

Table 9
System and Organization Controls Examination Definitions

SOC-1	SOC-2
Used to evaluate internal control over financial reporting and achieving compliance requirements. Focus is on controls at the service organization that would be useful to user entities or their auditors.	Addresses risk and opportunity associated with information technology over the trust services framework which includes: security, availability, processing integrity confidentiality, or privacy.

Source: Compiled by the Legislative Audit Division.

Depending upon the depth of the examination, each SOC report is further classified as either a Type-1 or Type-2 report. A Type-2 report indicates the auditor conducted tests of controls at the service organization, and the report includes specific information regarding the results of those control tests. In contrast, a Type-1 report does not include tests of service organization controls, nor does the report include results of such tests. Rather, a Type-1 report is limited to the auditor's observations of service organization controls in comparison to management's description of its control system and objectives.

During the period under audit, the department obtained SOC-1 Type-2 reports for systems that process medical claims for its Medicaid and CHIP programs. For some other systems, such as those used to process transactions for food and cash benefits, the department obtained a SOC-2 Type-2 report.

Electronic Benefits Transfer Service Organization

The department contracted with an electronic benefits processing service provider (EBT service provider) for its SNAP, TANF, and WIC federal programs. The EBT service provider is responsible for settlement, or payment, to retailers that have agreed to accept EBT cards for food (SNAP and WIC) or other (TANF) purchases. Because the TANF program provides cash assistance, EBT transactions are similar to those processed for any purchase made with a debit card. Based on services provided by the EBT service provider, we consider the entity to be a service organization. Table 10 represents the total amount of benefits processed by the department's EBT service provider for the above programs for fiscal years 2018 and 2019.

During the period under audit, the department received a SOC-2 Type-2 report for its EBT service provider. However, the SOC-2 report covered only the Security, Availability, and Confidentiality trust principles. The SOC-2 report did not address the Processing Integrity trust principle, which considers whether system processing is complete, accurate, timely, and authorized. The department overlooked the need to include the Processing Integrity trust principle relevant to system controls.

Recommendations #8 and #9 discuss improvements for the department's internal control and compliance regarding its EBT service provider.

Table 10
Benefits Processed by EBT Service Provider

	Fiscal Year 2019	Fiscal Year 2018
SNAP	\$149 million	\$163 million
TANF	\$22 million	\$32 million
WIC	\$6.5 million	\$7.5 million

Source: Compiled by the Legislative Audit Division.

Required Service Organization Examination

The department does not have adequate internal controls to ensure transactions were processed in compliance with the federal SNAP, TANF, and WIC program requirements. The department has not complied with federal requirements to obtain an examination of its EBT service provider.

Prior to transitioning to the current EBT service provider in June 2017, the department conducted extensive testing and certification of system controls and processes for the SNAP program. Results of similar testing during the period prior to transition for the TANF and WIC programs, which were implemented in June 2017 and September 2017, respectively, were provided by the department. As a result, the department is able to demonstrate that the system was properly designed at the time of implementation for each the TANF and WIC programs.

For the SNAP program, federal regulations require the department to obtain an annual SOC-1 Type-2 examination by an independent auditor of the transaction processing of the EBT service provider. The department was unaware of this federal requirement. While the SOC-1 examination is not required in federal regulations for the TANF and WIC programs, as mentioned above, obtaining a SOC examination is a common method used to ensure expectations of the service organization are being achieved.

Without the annual SOC-1 examination or the documented three-way reconciliation described in the following section, the department is not in compliance with related SNAP program federal regulations. Additionally, without updated EBT service provider assurances provided by a SOC-1 report, the department is unable to fully demonstrate it has established and maintained adequate internal controls to ensure federal program requirements are met for its SNAP, TANF, and WIC programs for the entire audit period. Additionally, the department is at risk for reporting incomplete or inaccurate information to the federal government, providing incorrect benefit amounts to clients, and over- or under-drawing benefit reimbursements for its federal programs.

RECOMMENDATION #8

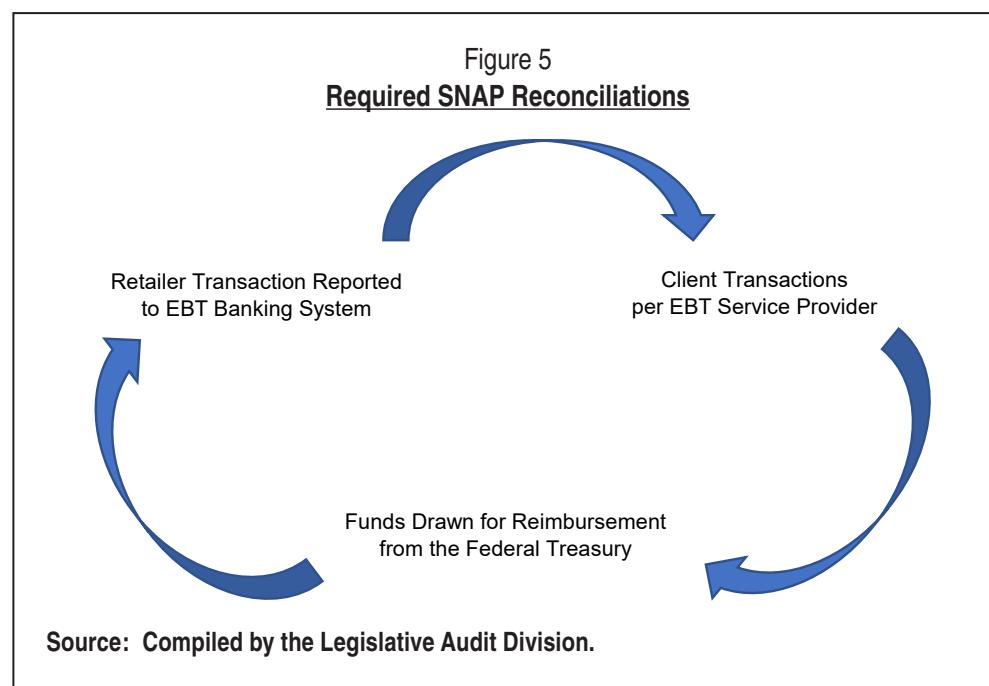
We recommend the Department of Public Health and Human Services:

- A. Obtain an annual SOC-1 Type 2 report over the electronic benefits processing service provider for Supplemental Nutrition Assurance Program, as required by federal regulations.
- B. Establish and maintain adequate internal controls to ensure Supplemental Nutrition Assurance Program, Temporary Assistance for Needy Families, and Special Supplemental Nutrition Program—Women, Infants and Children benefit transactions achieve applicable compliance requirements.

Required SNAP Reconciliation

The department did not complete all required reconciliations over SNAP benefits information. Department internal controls did not demonstrate complete follow-up on discrepancies in reconciliations.

Federal regulations require the department to reconcile all of the benefits issued, redeemed, and unredeemed each day with the state's drawdown account with the federal government and with EBT service provider records, as illustrated in Figure 5 below.



Specifically, the department is required to compare the following three data sources to each other:

- ♦ Retailer transactions reported to the EBT banking system—these are transactions processed by the retailer (grocery store/vendor) on behalf of the SNAP client.
- ♦ Client transactions maintained by the EBT service provider—this is SNAP benefits redeemed.
- ♦ Funds drawn for reimbursement from the federal treasury—as permitted by federal regulations, the EBT service provider draws state benefit reimbursements directly from the federal government.

During the period under audit, two-way reconciliations were conducted, but the required three-way reconciliation was not completed. Additionally, when partial reconciliations were completed, the department did not consistently document its follow-up and resolution of differences identified.

A daily two-way reconciliation conducted by the department compares benefits issued per the department's system to the benefits applied to client EBT cards according to EBT service provider reports. In our sample of 44 of these reconciliations, the department did not document the reason for the difference for 7 reconciliations.

The two-way reconciliation described above did not incorporate retailer transaction activity or the drawdown activity from the federal treasury. For the required three-way reconciliations not completed, department staff believed there were adequate controls in place at the EBT service provider and relied on the EBT service provider to complete the reconciliations. However, the department was not able to provide evidence that required reconciliations were completed by the EBT service provider. Additionally, due to the lack of a SOC-1 Type 2 report, the department does not have evidence about the reliability of data or procedures, including reconciliations, involving procedures at the EBT service organization, as discussed in Recommendation #8.

Without evidence to document the completion of all necessary reconciliations, the department is unable to confirm the accuracy of the SNAP benefits drawn by the EBT service provider on behalf of the state of Montana. Further, the department has no assurance that SNAP benefit draws were based on benefits redeemed by program participants at retailers. Due to lack of SOC-1 assurances and incomplete reconciliations discussed in these sections, we believe questioned costs related to SNAP benefits could exceed \$25,000 for the audit period.

RECOMMENDATION #9

We recommend the Department of Public Health and Human Services:

- A. *Establish and maintain adequate internal controls to ensure reconciliations of Supplemental Nutrition Assistance Program benefits issued, redeemed, and unredeemed are conducted, as required by federal regulations.*
- B. *Conduct and document follow-up on differences identified in required reconciliations.*

Federal Cash Draws

The department has permitted the EBT service provider to execute over \$300 million in federal cash draws for Supplemental Nutrition Assistance Program (SNAP) benefits, which is contrary to the state's Treasury State Agreement (TSA). Additionally, the department did not provide an update to the TSA for changes in its processes.

As part of its agreement with the EBT service provider, previously discussed in more detail in Recommendation #8, the department has authorized the EBT service provider to initiate and directly receive draws related to EBT benefits redeemed for the SNAP program. While the department is permitted to enter into such an agreement, the state's TSA with the federal government does not recognize the EBT contractor as the entity conducting the draws. The department continues to execute the federal cash draws for the administrative costs of the SNAP program. However, because the TSA specifies the department also conducts the draws for SNAP benefits, permitting the EBT contractor to perform the draws results in noncompliance with the state's TSA. Annually, the Department of Administration solicits input from state agencies regarding necessary changes to the TSA. The department overlooked the need to submit modification to the TSA for each fiscal year 2018 and 2019.

RECOMMENDATION #10

We recommend the Department of Public Health and Human Services:

- A. *Work with the Department of Administration to properly update the Treasury State Agreement for benefit draws related to the Supplemental Nutrition Assistance Program.*
- B. *Comply with the Treasury State Agreement by completing the Supplemental Nutrition Assistance Program benefit draws from the federal government until such time as the Treasury State Agreement is revised.*

Automated Data Processing (ADP) System Accuracy

The department's internal controls related to use of the Automated Data Processing (ADP) systems for SNAP could be strengthened in the following areas: follow up on results of the department's eligibility audits, training for staff completing eligibility determinations, and adequate support for federal reports. Additionally, all portions of SNAP reporting are not automated by the ADP system, as required by federal regulation.

Federal regulations require the department automate its SNAP operations to obtain, maintain, utilize, and transmit program information. This includes:

- ◆ Determining eligibility, calculating benefits, or validating the eligibility of workers' calculations by processing and storing all information necessary for eligibility determination and benefit calculations, as well as identifying and alerting department staff and clients when eligibility or benefit changes occur.
- ◆ Providing an automatic cutoff of participation when annual renewal information and procedures are not provided.
- ◆ Generating data necessary to meet federal issuance and reconciliation reporting requirements. Specifically, the SNAP information system must produce data for the federal FNS-46 SNAP Issuance Reconciliation Report and the FNS-209 Status of Claims Against Households report.

System Automation and SNAP Eligibility

We reviewed the top ten reasons for audit eligibility errors for each federal fiscal year 2018 and 2019, as reported by the department's internal audits of SNAP eligibility determinations and benefits calculations, because the department indicated these audits were a key control for the SNAP ADP systems compliance requirement. Each

of the ten reasons had underlying issues reported. We were testing to see if there were patterns to indicate the information in the department's eligibility system (CHIMES) was inaccurate or that the system was not working effectively. In total, the department identified 9 instances where errors were the result of computer programming issues. Additionally, the department's internal audits identified 48 errors due to incorrect case file information, and an additional 58 errors resulting from information being disregarded or not applied in eligibility determinations and benefit calculations.

While the department shares the results of the monthly eligibility audits with SNAP program staff, eligibility errors continued to remain high for the audit period. The department cites staffing shortages and inadequate staff training as reasons for the increased eligibility errors. Due to the department exceeding the national average payment error rate for federal fiscal year 2018, a liability of \$582,874 was imposed by the federal government. The state has the option of settling with the federal government by paying the liability in full, or by designating state funds totaling 50 percent of the fine for new investment in approved activities to improved administration of SNAP. The department has chosen for the 50 percent investment option. This option also requires the department set aside the remaining 50 percent of the fine for repayment to the federal government if the fiscal year 2019 payment error rate once again determined excessive. The Governor and Legislative leadership received letters which explained the liability from the federal government in July 2019.

Reporting

As noted above, the FNS-46 and FNS-209 reports must be fully automated, as required by federal regulations. The department uses the Accounts Receivable Management System (ARMS) to track SNAP accounts receivable. While most of the information for the FNS-209 report is generated from ARMS, the beginning balance for the report must be manually adjusted because ARMS is not designed to report beginning balances. The department is able to retrieve accurate beginning balances from the federal system. However, since the beginning and ending balances are defined as key line items for federal reportage, we believe the balances should be automated.

We noted the FNS-46 report is completed via full automation using SNAP information from the service organization discussed in Recommendation #8. While the department completes a daily reconciliation between the department's eligibility system and the service organization's system for newly issued SNAP benefits, the department does not complete and document a monthly reconciliation which supports the information included on the FNS-46 report. In conjunction with the lack of SOC assurances over the service organization, as reported in Recommendation #8 above, we consider this to be a weakness in internal control for the SNAP program.

Summary

The department has not complied with federal regulations which require data systems to contain complete and accurate information and automatic reporting. Additionally, the accuracy of information included in required federal reports is at risk due to identified deficiencies in internal controls.

RECOMMENDATION #11

We recommend the Department of Public Health and Human Services enhance internal control and compliance with federal regulations for the Supplemental Nutrition Assistance Program by:

- A. *Maintaining documentation to demonstrate consideration of the results of monthly Quality Assurance Division eligibility audits.*
- B. *Conducting and documenting training for staff completing eligibility determinations to address common errors, when identified by monthly Quality Assurance Division eligibility audits.*
- C. *Updating the Accounts Receivable Management System to automatically generate the beginning balances for the FNS-209 quarterly reports, as required by federal regulations.*
- D. *Ensure the FNS-46 report is supported by accurate information via an audit of the EBT service organization or a documented monthly reconciliation.*

Temporary Assistance for Needy Families

The Temporary Assistance for Needy Families (TANF) program objectives are to provide time-limited assistance to needy families with children so the children may be cared for in their own homes, and to end dependence on government benefits by promoting job preparation, work, and marriage. During the audit period, the department disbursed nearly \$70 million in federal funds to TANF families. The next three sections discuss how the department can improve controls and compliance over the TANF program.

Income Eligibility and Verification System

The department did not use income information from the Internal Revenue Service (IRS) in making eligibility determinations. Additionally, in some instances department internal controls were insufficient to allow for IRS information obtained to be used.

Twice per year, federal Income Eligibility and Verification System (IEVS) regulations require the department to coordinate data exchanges with other federally assisted benefit programs, request and use benefit information in making eligibility determinations, and adhere to standardized formats and procedures in exchanging information with other agencies. One required data exchange is with the IRS for unearned income information.

Federal regulations require the department to download this specific IRS tax data and to compare the download to information provided by TANF program participants to determine their income qualification and appropriate level of assistance. Department management cite one section of United States Code which specifies no state shall be required to use the IRS information to verify the eligibility of all recipients. We agree the IRS information is not required to verify the eligibility of all recipients. However, other federal regulations require the IRS data be used in conjunction with other information for determining an individual's eligibility and amount of assistance, as well as changes to eligibility.

Our prior audit reported the department obtained the required information but was not subsequently using the information in evaluating eligibility and assistance determinations. During the current audit, we determined the department was able to complete the IRS data comparison one of the four times it was required. In two instances, the comparison was not conducted because the department was unable to convert the IRS data into a usable format. In another instance, the department did not receive the file requested from the IRS and did not follow up to ensure data

was received. Overall, the department did not comply with the required IRS data comparison for the audit period. Without fully using the IRS data to evaluate eligibility and assistance determinations, the department risks errors in benefit costs incurred for the TANF program.

Although the department requested information from the IRS, the department's procedures documents did not instruct staff when or how to follow up when a file was not returned from the IRS. Additionally, procedures documents did not instruct staff regarding the conversion of the IRS data. Department staff also suspect IRS files were not provided or were provided late due to federal government shut downs.

RECOMMENDATION #12

We recommend, with respect to the Temporary Assistance for Needy Families program Income Eligibility and Verification System requirements, the Department of Public Health and Human Services:

- A. *Develop and maintain internal controls to ensure staff follow up when the file from the IRS is not received timely, and properly convert the file to a usable format upon receipt.*
- B. *Comply with federal regulations by comparing income information obtained from the Internal Revenue Service to information contained in the individual case records in order to determine the effect, if any, on individuals' eligibility or amount of assistance.*

Tracking Extended Benefits

The department's spreadsheet to track cases with extended benefits for the TANF program was incomplete.

Federal regulations limit the number of families who can participate in the TANF program for more than 60 countable months. The average number of families including a head of household receiving assistance for more than 60 months cannot exceed 20 percent of the average monthly number of all families in the program.

The department maintains a spreadsheet to track the number of cases receiving TANF benefits beyond 60 months. During the audit, we compared the department's tracking spreadsheet to a listing from the Combined Healthcare Information and Montana Eligibility System (CHIMES) and noted the department's tracking spreadsheet was

not complete. The spreadsheet listed 17 cases while the CHIMES report listed 35 cases. Based on an average monthly TANF caseload of 3,614, the department may allow up to 723 TANF participants to exceed 60 countable months of assistance under the program. The prior year average monthly caseload was 4,355.

Although our audit did not identify an excess number of participants exceeding the 60-month limitation for TANF assistance, without maintaining an accurate tracking mechanism, the department is at risk of exceeding the limitation outlined in federal regulation without detection. Department staff cite human error as the reason the tracking spreadsheet was incomplete.

RECOMMENDATION #13

We recommend the Department of Public Health and Human Services develop and maintain internal controls, in accordance with federal regulations, to ensure its tracking spreadsheet for recipients of extended Temporary Assistance for Needy Families benefits is complete.

Federal Reports

Contrary to instructions for federal reporting, federal reports included expenditures which were incurred by the state after the reporting period ended.

During the audit, we reviewed two of the eight quarterly federal financial reports required for the TANF program. In the report submitted for the period ended September 30, 2018, as revised in December 2018, we noted the department included expenditures which were not incurred by the state until after the reporting period had ended. Specifically, we noted total federal expenditures for the 2017 grant were over-stated by \$2.2 million on the September 2018 report because the department had included costs incurred through December 2018.

Instructions for federal financial reporting indicate revisions for unliquidated obligations should be made only when changes to the previously reported expenditure amount affects the amount of remaining unliquidated obligations. As an example, an unliquidated obligation exists when a contract for current and future services is in place. Unless an actual payment has been made towards the obligation during the reporting period, remaining obligated amounts are presented as unliquidated (or unpaid) obligations rather than expenses in the federal report.

Regarding the additional amounts reported by the department, because the costs were not incurred by the state until after September 30, there is no impact on unliquidated obligations. Therefore, costs incurred after September 30 should not be included on the report for the period ended September 30. Instead, these costs should be included on the appropriate quarterly federal award report for the next federal fiscal year.

RECOMMENDATION #14

We recommend the Department of Public Health and Human Services:

- A. *Include only current cumulative expenditures in its federal Temporary Assistance for Needy Families quarterly reports.*
- B. *Develop and implement internal controls to ensure only expenditures incurred during the reporting period are included on federal Temporary Assistance for Needy Families quarterly reports.*

Foster Care

The department's Foster Care program provides safe, appropriate, 24-hour substitute care to children in need of care outside their homes. During the audit we identified improvements related to the department's reporting process, as discussed in the following four sections.

Procurement for Services

Contrary to state procurement policies and federal regulations, the department continues to make payments to vendors for services without having a contract in place.

Our prior audit included a recommendation that the department comply with state laws and federal regulations by following state procurement policies to obtain services for the Temporary Assistance for Needy Families (TANF) and Foster Care programs. The department disagreed with our recommendation as they believe the services in question are exempt from procurement requirements based on state statute. The Administration for Children and Families, a division of the federal Department of Health and Human Services, sustained our audit finding and recommendation, but did not pursue a monetary penalty against the department.

As permitted by federal regulations, the department can use a portion of its federal TANF funds to pay costs associated with children in Foster Care. During the audit period, the department did not follow federal regulations and state procurement policies when incurring over \$6 million in total costs from all funding sources for nonmedical services for the Foster Care program. Our review was limited to service costs for one-on-one supervision of youth, chemical dependency evaluations, urine analyses, and support services for children placed in the Foster Care program. Our prior audit determined these services did not meet the statutory exemption in state law for services from health care providers because these services are not provided by health care providers. We identified four vendors whose total annual payments exceeded the department's delegation agreement level of \$200,000, which requires a formal competitive procurement process, including additional oversight from the Department of Administration, be followed.

Federal regulations require the department to follow the same policies and procedures used for nonfederal funds when procuring property and services under a federal award.

In its delegation agreement with the Department of Administration's Procurement Bureau, the department may use the following procurement methods:

- ◆ **Small Purchases:** For total contract value of \$5,000 or less, the department may choose a purchasing technique that best meets its needs.
- ◆ **Limited Solicitations:** For total contract value between \$5,001 and \$25,000, the department must obtain and document prices from a minimum of three viable sources.
- ◆ **Formal Competition:** For total contract value between \$25,001 and \$200,000, the department must use either an invitation for bid or request for proposal process.
- ◆ **Sole Source:** For total contract value up to \$200,000, the department determines whether a purchase qualifies as sole source.

Federal regulations further specify the type of procurement methods the state must follow for its public welfare programs, and require a competitive process for all procurements in excess of \$150,000. By not following applicable procurement procedures, payments to these vendors are not an allowable use of TANF funds. As a result, we question \$805,539 in costs for the TANF program

RECOMMENDATION #15

We recommend the Department of Public Health and Human Services comply with state law and federal regulations by following state procurement policies to obtain services for one-on-one supervision of youth, chemical dependency evaluations, urine analyses, and support services for a child placed in the Foster Care program using Temporary Assistance for Needy Families funds.

Contracts Involving Federal Awards

Federal regulations require the department to include certain information and provisions in contracts involving federal funds when procuring property and services under a federal award. Additionally, federal regulations require the department to monitor payment requests for contracts to ensure costs are allowable under the federal award prior to making payment.

The following two sections discuss the need for department improvements in contract monitoring and content for its Foster Care program.

Foster Care Contract Contents

Department procedures did not detect omissions from subrecipient agreements, and did not include required subrecipient disclosures in newly signed subrecipient agreements with the state's tribal organizations for the Foster Care program.

Federal regulations require the department to inform subrecipients of specific federal award information, and include that information in the subrecipient agreement. Required contract disclosures include, but are not limited to:

- ◆ The federal award identification number,
- ◆ Amount of federal funds obligated to the subrecipient,
- ◆ Applicable indirect cost rates for the federal award,
- ◆ Catalog of Federal Domestic Assistance (CFDA) title and number,
- ◆ Federal awarding agency,
- ◆ Award name and number,
- ◆ Award year,
- ◆ Permission for department officials and auditors to have access to the subrecipient's records, and
- ◆ Terms and conditions concerning the closeout of the subaward.

In our department audit report (15-14) for the two fiscal years ended June 30, 2015, we recommended the department properly classify its agreements with the state's tribal organizations as subrecipients, and comply with all federal regulations regarding subrecipients. Because the department had incorrectly classified the tribal organizations as vendors rather than subrecipients, the related agreements with the tribal organizations were missing required subrecipient disclosures. In our audit of the department for the two fiscal years ended June 30, 2017, we concluded the recommendation was partially implemented and made no further recommendation because the department represented it intended to include the subrecipient language in the next tribal agreements which were due in fiscal year 2018.

In November 2017, the department signed new agreements with seven tribal organizations. None of these new agreements include the required subrecipient disclosures. Department staff overlooked the need to include the subrecipient disclosures for the newly signed Foster Care contracts. In addition, the department's agreements with two institutions of higher education which provide services under the Foster Care program are also missing the required subrecipient disclosures. As a result, the department has not complied with federal regulations regarding required

subrecipient disclosures. Additionally, failure to provide subrecipients with the required federal award information increases the risk of subrecipient noncompliance with federal requirements because the subrecipient may not properly report how they have received and expended federal funds.

RECOMMENDATION #16

We recommend the Department of Public Health and Human Services:

- A. *Establish and document internal controls to ensure required subrecipient disclosures are included in Foster Care contract agreements prior to signature.*
- B. *Comply with federal regulations by including required subrecipient disclosures in Foster Care contract agreements.*

Foster Care Contract Payments

The department incurred training-related costs without obtaining detailed documentation to support the costs were allowable under the federal Foster Care requirements. Additionally, department internal controls for certain Foster Care payments require strengthening.

The department maintains Foster Care contracts with seven tribes and two institutions of higher education (colleges). Foster Care funds are provided to these entities to either help administer the Foster Care program, provide stipends to college students studying social work, or to provide training to department staff. In order for costs to be allowable under federal regulations, the cost must be:

- ◆ Adequately documented,
- ◆ Training activities must be included in the department's training plan,
- ◆ Grants to educational institutions must be made for the purpose of developing, expanding or improving training for department personnel or individuals preparing for employment with the department, and
- ◆ For stipends, the department must select the recipient who is then accepted by the college.

Supporting Documentation

We sampled 17 invoices from a total of 176 transactions totaling \$4.1 million which were submitted by tribes or the colleges. Our sample identified 15 instances where

supporting documentation did not exist or was not detailed enough to determine whether the costs were allowable. Examples are described below.

- ◆ Support for one college invoice consisted of a printout of monthly expenditures incurred by the college, but there were no supporting receipts or details to indicate what was purchased. The listing also showed payroll costs incurred, but supporting documentation was neither specific as to which employees were paid nor for what purpose. As such, we were unable to determine whether the costs incurred by the college were authorized under the contract and allowable for reimbursement via the Foster Care program.
- ◆ Support for one tribal payment consisted of a standardized billing invoice, which is utilized by all of the tribes, that outlined personnel positions under the contract, the individual salaries including fringe benefits of the personnel, and operating expenditures. Because no other support was provided by the tribe, we could not verify if the expenditures outlined on the invoice actually were incurred.

Training Costs

Of the 17 invoices tested, 8 were transactions related to training costs. Because the invoices did not specify the training task being billed, we reviewed the entire contract in comparison to the associated training plan. Our review identified several activities outlined in the contract which were not included in the training plan. We also identified contract budget items which are specifically disallowed or only permitted under specific circumstances under federal regulations. Costs incurred for these items are considered questioned costs, and are summarized in the following table:

Table 11
Foster Care Contract Items Not Allowed Under Federal Regulations

Contract Budget Item	Contract Budget Amount	Federal Regulations Summary
Salaries for Directors/Supervisors	\$408,176	Federal reimbursement is not allowed for salaries of supervisors as they are not considered training activity. If conditions for matching as administrative costs are met, federal funds could be used for 50% of these costs.
Stipends (basic living allowance paid to a student)	\$561,000	The department inappropriately delegated selection of stipend recipients to the college.
Total	\$969,176	

Source: Compiled by the Legislative Audit Division.

As noted in the table above, salaries for directors or supervisors are allowed at 50 percent of the associated costs if certain conditions are met. We noted in our review of both the contract budgets and payments that federal monies were the only source of funding

planned and spent on these activities. Additionally, department management claims department staff actively participated in the selection process for stipend participants. However, the department did not provide evidence to support this claim. As such, we question costs reflected in the table totalling \$969,176 for the period under audit.

For tribal and college payments, the department believes the documentation it maintains is sufficient. Billing forms submitted to the department contain summarized information for wages, benefits, travel costs, and other administrative cost categories. We did not observe evidence where additional supporting documentation other than the billing form was obtained. Department staff indicate they do not review supporting documentation when performing site visits for the tribes. Additionally, the department contends its contracts with colleges include directives on appropriate accounting and billing practices, as well as language which would allow for the acquisition of additional information if there is a billing question. However, during the audit period, the department did not request such clarifying information to ensure the underlying activity was for allowed activities related to its training program. Likely questioned costs could exceed \$4 million, the value of the college training contracts, if other services billed by the college do not align with federal program requirements or do not directly benefit the department's training program.

RECOMMENDATION #17

We recommend the Department of Public Health and Human Services:

- A. *Reimburse colleges and tribes only for activities allowed by federal regulation for the Foster Care program.*
- B. *Design and implement internal control to ensure detailed support for college and tribal invoices is obtained, reviewed, and approved prior to payment.*

Federal Reports

The department lacks internal control to ensure all required information is included in Foster Care reports to the federal government, which resulted in incomplete and inaccurate reports submitted for the audit period.

Using the Foster Care CB-496 report, the department reports current expenditures and information on children assisted for the quarter that has just ended. Per instructions

for report completion, the federal share of child support collections on behalf of Foster Care eligible children should be included in Part 1 of the report. In our review, we noted the child support recoveries were excluded from 4 out of 8 reports submitted for the audit period. Internal control procedures did not direct department staff to include these collections in Line 1 of the CB-496 report. Additionally, department staff indicate child support recoveries are less than \$20,000 per quarter, and as such, the variance between quarters was not significant enough to trigger additional follow-up prior to report submission.

Without adequate internal control, the department continues to risk submitting incorrect and incomplete information in its Foster Care reports. Additionally, the department was unable to demonstrate compliance with federal internal control requirements over reporting.

RECOMMENDATION #18

We recommend the Department of Public Health and Human Services design and implement internal control to ensure child support recoveries are properly reported on its Foster Care CB-496 reports.

Child Care Development Fund

The federal Child Care Development Fund (CCDF) program provides funds to states to increase the availability, affordability, and quality of child care services. Funds are used to subsidize child care for low-income families where the parents are working or attending training or educational programs, as well as for activities to promote overall child care quality for all children, regardless of subsidy receipt.

Multiple types of funding are involved in the CCDF program, as defined below.

- ◆ **Mandatory Funds**—general entitlement child care funds. These are federal funds made available to the department based on a formula outlined in the federal Social Security Act. State matching funds are not applicable to mandatory funds.
- ◆ **Discretionary Funds**—are authorized under the federal Child Care and Development Block Grant Act, and are awarded, among other things, to afford states maximum flexibility in developing child care programs that best suit the needs within the state.
- ◆ **Matching Funds**—after federal mandatory funds are awarded by the federal government, remaining federal appropriation can be granted via Matching Funds. When awarded, the department must expend its state resources when using federal matching funds.

The following three sections discuss improvements necessary in the department's internal control and compliance with CCDF requirements.

Period of Performance

The department does not have internal controls in place to ensure CCDF funds are obligated as required by federal regulations, and complete evidence of such obligation has not been provided by the department.

Obligation of funds is defined in federal regulation as orders placed for services or contracts and subawards made that require payment by the department. Once obligations are made, related payments could occur in the current or future periods, which is commonly referred to as the period of performance for the federal award. Federal regulations further require Mandatory, Discretionary and Matching funds be obligated within certain time frames, as outlined in Table 12 (see page 53).

Table 12
Obligation Requirements for Child Care Development Funds

CCDF Funding Type	Obligation Requirements in Federal Regulation
Mandatory	When matching funds are received, these mandatory funds must be obligated by the end of the fiscal year in which the funds are granted.
Discretionary	Must be obligated by the end of the second fiscal year after the award.
Matching	Both the federal and state share of matching funds must be obligated in the fiscal year in which the funds are granted.

Source: Compiled by the Legislative Audit Division.

In both fiscal years under audit, the department received a Matching Fund grant for CCDF. The department must obligate its Mandatory Funds prior to being eligible to receive Matching Funds.

Under the CCDF program, the department contracts with entities around the state who evaluate needs and authorize certificates to families for reduced cost child care. In relation to these contracts, we requested support to confirm the Mandatory and Matching Funds were obligated by the end of the fiscal year they were granted, as required by federal regulations. The department responded they obligate the Mandatory Funds through their certificate plans using historical data and projections based on caseload. Federal regulations allow for an obligation to occur when there is a contract with a third-party for determining eligibility and issuing child care certificates. While the department provided a chart to demonstrate expenditures tracking, the tracking mechanism lacked detail by individual federal grant award or by types of expenditure such as certificates or grant payments. As such, we have no evidence to confirm full obligation of each federal grant award occurred within the required time frame.

Because the department was unable to provide detailed evidence of the obligation amounts, we can only conclude the department has not obligated its Mandatory or Discretionary funds. Additionally, because the department has not obligated its Mandatory Funds, it is not eligible to receive federal Matching Funds. As such, we question Matching Funds received by the department totaling \$9,158,195. We also question unobligated Mandatory Funds of \$3,166,460.

RECOMMENDATION #19

We recommend the Department of Public Health and Human Services:

- A. *Develop internal controls to document the obligation of all funding types for the Child Care Development Fund federal award.*
- B. *Ensure obligation for Mandatory, Discretionary, and Matching funds for federal Child Care Development Fund awards occurs within the timelines required in federal regulation.*

Health and Safety Requirements

The department's internal control did not ensure federally-required elements were included in its health and safety inspections of day-care facilities which resulted in noncompliance with federal regulation.

Federal regulations outline ten health and safety requirements which are required for child care providers receiving subsidies under the CCDF program. For the department, these ten requirements were effective February 28, 2018, the date of its extension provided by the federal government. The department completes inspections of day cares using a "Key Indicator Summary" or KIS for lower risk day cares. During the audit, we tested health and safety elements items against the KIS inspection template, because the KIS inspections have the least amount of testing and are therefore the riskiest in terms of not having all the required elements. Most of the health and safety elements were not being tested on the KIS inspections during fiscal year 2018. Some, but not all, missing elements were incorporated to the KIS in fiscal year 2019, as summarized in Table 13 (see page 55).

Table 13
Health and Safety Standards and Audit Observations for CCDF Award

Federally-Required Health and Safety Standard Element	Required Elements Included on Monitoring Form or Desk Review	Audit Observations for Items Omitted
Prevention and control of infectious diseases (including immunization)	Partially included on Monitoring Form	State rules do not allow a grace period for homelessness or for children in Foster Care, as required by federal regulation.
Prevention of sudden infant death syndrome and use of safe sleeping practices	Included in Desk Review	For four months of the audit period, the department did not test all required safe sleeping elements.
Administration of medication consistent with standards for parental consent	Yes	
Prevention of and response to emergencies due to food and allergic reactions	Partially included on Monitoring Form	The requirement for facilities to have a plan for preventing and responding to food and allergic reaction emergencies is missing from the monitoring form.
Building and physical premises safety	Yes	Electrical hazards omitted from the monitoring form for four months of the audit.
Prevention of shaken baby syndrome and abusive head trauma	Included in Desk Review	Trainings have not been added to the monitoring form for fiscal year 2019.
Emergency preparedness and response planning for emergencies	No	State policy was added during the audit period, but emergency plans are missing from the monitoring tool.
Handling and storage of hazardous materials and appropriate disposal of bio contaminants	Partially included on Monitoring Form	State policy was added during the audit period, but handling and storage of hazardous materials and disposal of bio contaminants are missing from the monitoring tool.
Precautions in transporting children	Yes	
First aid and cardiopulmonary resuscitation	Included in Desk Review	Documentation of training is not included on the monitoring form.

Source: Compiled by the Legislative Audit Division.

As a result, the department has not complied with federal regulations regarding health and safety standards for all day cares for the period under audit. Department staff indicate they do not update the monitoring form each year. Additionally, department staff said they overlooked certain elements of the health and safety requirements because the department previously required the emergency plan and fire drill record be submitted and therefore not included in the checklist.

RECOMMENDATION #20

We recommend the Department of Public Health and Human Services:

- A. *Ensure all health and safety standards are considered in its reviews of day-care facilities for the Child Care Development Fund program, as required by federal regulation*
- B. *Enhance internal control for the Child Care Development Fund program by updating its day care monitoring form to ensure all health and safety elements are included.*

Recovery of Fraud Overpayments

The department did not attempt to recover overpayments from recipients in 8 of 11 cases identified as fraud by the department during the audit period.

Our prior audit included a recommendation to the department to develop internal control procedures to ensure coordination between CCDF program staff and Business and Financial Services Division (BFS) staff for recovering overpayments resulting from fraud, and to seek timely recovery for all identified fraudulent child care overpayments. In response to the prior audit, the department developed an internal control procedure to use a communication form to convey fraudulent overpayment information to BFS. The communication form was completed for 10 of 11 fraudulent overpayments identified during the audit. However, repayment was only sought for 3 of the 11 fraud cases.

According to federal regulations, the department must recover child care payments that are the result of fraud. While overpayments were communicated to BFS, the employee responsible for entering the information to the system which tracks overpayments was using an outdated procedure which indicated the cases should be marked with an indicator which prevents a recovery invoice from being generated. Since bringing this to the attention of department staff, the procedure has been updated and recovery letters are being sent to initiate collections.

Because the department did not comply with the requirements to recover fraudulent overpayments, we question \$20,014 in federal costs associated with the 8 instances discussed above for the CCDF program.

RECOMMENDATION #21

We recommend the Department of Public Health and Human Services:

- A. *Develop internal control procedures for the Child Care Development Fund program to confirm letters have been sent and collections initiated when required for fraud cases.*
- B. *Comply with federal regulations by seeking timely recovery of all identified fraudulent child care overpayments for the Child Care Development Fund program.*

Centrally Provided Services

In the administration of its federal programs, the department achieves organizational efficiencies by conducting certain functions through a centralized group of employees. Functions completed by centralized groups include: cash draws from the federal government; allocations of expenditures to the programs benefitting from those costs (known as Cost Allocation); oversight of the planning, implementation and operation of information system technologies; and accounting functions such as payroll processing. During the audit, we noted areas where the department can improve its internal control and compliance with federal regulations, as discussed in further detail below.

Cost Allocation

Based on sample results, the department did not follow its federally approved plan to allocate costs among state and federal funding sources. Additionally, department internal controls did not identify these inconsistencies.

Federal regulations require the department, as a public assistance agency of the state, to develop, document, and implement a cost allocation plan, which is a process by which costs benefitting more than one program or activity are identified and allocated on a consistent and equitable basis. The cost allocation plan discusses both direct and indirect cost pools. Direct costs are recorded to a single project or program, while indirect costs are authorized for allocation to specified projects or programs. Regardless of classification as a direct or indirect cost, to be allowable under federal regulations, the federal program must directly benefit from the underlying activity. For example, a cost allowable to a single program as a direct cost could become unallowable if allocated as an indirect cost to other unrelated programs.

During the period under audit, the department allocated costs under three different cost allocation plans. In total the department allocated \$66.5 million and \$80.6 million in costs for fiscal years 2018 and 2019, respectively. Monthly, there are approximately 140 cost pools for which the department allocates costs. In our sample of 56 cost pool allocations, we noted the following exceptions to compliance with the applicable cost allocation plan:

- ◆ For the *Operations Branch Manager Indirect Cost Pool*, costs should be allocated by full-time equivalent (FTE) staff who are directly supervised by the Operations Services Branch Manager. We tested the November 2018 and December 2018 allocations, and noted in each month the department did not include all FTE which are directly supervised by the branch manager.
- ◆ For the *Financial Technical Analyst Indirect Cost Pool*, the department began using a new allocation method in June 2018, prior to its September 2018 submission to request an amendment to its Cost Allocation Plan.

- ◆ The *Technology Services Division (TSD) Administrator Indirect Cost Pool* is allocated by FTE directly supervised by the TSD Administrator. We reviewed the June 2019 allocation, and noted FTE not supervised by the TSD Administrator were included in the pool. For the September 2017 and July 2018 allocations, costs associated with one FTE were inappropriately excluded from the calculation.
- ◆ Costs associated with the *County Use Allowance Indirect Cost Pool* were allocated as a distinct cost pool beginning in July 2017, but the pool was not included in the department's Cost Allocation Plan until May 2018.
- ◆ The *Reimbursement Travel Indirect Cost Pool* was utilized by the department for at least nine months prior to its inclusion in the department's Cost Allocation Plan as a distinct cost pool in May 2018.
- ◆ The April 2018 allocation for the *Office of the Medicaid and Health Services Branch Manager Indirect Cost Pool* used time and effort reporting as its allocation method, rather than FTE directly supervised by the Medicaid and Health Services Branch Manager, as specified in the department's Cost Allocation Plan.

As a result of all sample errors, the department has not complied with its federally-approved cost allocation plans. For the *County Use Allowance Indirect Cost Pool* and the *Reimbursement Travel Indirect Cost Pool*, allocation changes were made prior to submitting a revised cost allocation plan to the federal government. Department management indicates these new cost pools did not result in changes to how costs were allocated among federal programs. As such, we have excluded these cost pools from our projection of questioned costs discussed below.

We project questioned costs totaling \$724,658, as summarized in the table below. We limited our questioned costs to federal programs with indirect cost activity exceeding or approaching \$25,000 in the *Operations Branch Manager Indirect Cost Pool*, the *Financial Technical Analyst Indirect Cost Pool*, and the *Technology Service Division Administrator Cost Pool*. Based on the number of discrepancies between the approved cost allocation plan and the department's allocation of indirect costs, additional discrepancies not identified in our sample likely exist. These additional discrepancies could

Table 14
Summary of Questioned Costs from Cost Allocation Errors by Federal Program
 Fiscal Years 2018 and 2019 Combined

Federal Program	Questioned Costs
Medicaid	\$373,551
CCDF	\$109,909
SNAP	\$70,571
Child Support Enforcement	\$67,509
TANF	\$48,960
CHIP	\$29,745
Foster Care	\$24,413
Total	\$724,658

Source: Compiled by the Legislative Audit Division.

include additional unallowable costs and could potentially impact all programs administered by the department.

Department staff indicate human error or oversight, controls insufficient to detect variances in cost pools based on full-time equivalent staff statistics, and commingling costs associated with multiple staff to a single task profile cost as reasons for the allocation errors. Department staff also included costs anticipating a back-dated approval of changes as requested from the federal government for the Financial Technical Analyst Indirect Cost Pool.

RECOMMENDATION #22

We recommend the Department of Public Health and Human Services:

- A. *Conduct and document a review of all cost pools to ensure department procedures align with the approved cost allocation plan.*
- B. *Implement changes to the cost allocation process only after receiving approval from, or submitting a plan revision to, the federal government.*
- C. *Develop and implement internal control to detect variances in cost pools based on a full-time equivalent staff statistic.*
- D. *Allocate costs as specified in the cost allocation pool, as required by federal regulations.*

Cash Management

Federal regulations require the department to minimize the time between payment of expenditures and receiving federal funds to ensure the draws are revenue-neutral for both state and federal governments. For selected large federal programs, the State enters into an agreement with the federal government, known as the Treasury-State Agreement (TSA), which directs when and how reimbursement is requested. During the period under audit, the department had an opportunity annually to suggest modifications to the TSA and did not make any such suggestions.

For programs not included in the TSA, federal regulations require the department minimize the time between the drawdown of federal funds and their disbursement for federal program purposes. The timing and amount of funds transferred must be as close as feasible to the department's cash outlay for direct and indirect program costs. In contrast, state law requires non-general fund money be expended prior to other funding sources. When the department delays its draws of federal funds, in substance, the general fund is loaning money to the federal fund.

Recommendation #10 previously addressed a necessary update to the TSA. The following three sections discuss additional improvements in the department's cash management processes.

Low-Income Home Energy Assistance

For the second consecutive audit, the department has not conducted cash draws for the Low-Income Home Energy Assistance Program (LIHEAP) in accordance with the federal agreement.

Our prior audit noted the department used a four-day clearance pattern for LIHEAP warrants rather than the five-day clearance pattern specified in the TSA. For at least 18 months of the current audit period, we noted the department systemically recorded LIHEAP expenditures on a tracking spreadsheet the day after the costs were incurred, which caused the department to draw cash following a six-day clearance pattern for warrants. Total federal draws related to warrants were approximately \$3 million for each year of the audit period. Although the department has not drawn funds in advance of the timing permitted by the TSA, the five-day clearance pattern is considered revenue-neutral and remains the requirement under the TSA agreement.

RECOMMENDATION #23

We recommend the Department of Public Health and Human Services:

- A. *Develop internal review processes to ensure staff apply the clearance pattern approved in the Treasury State Agreement for Low-Income Home Energy Assistance program cash draws.*
- B. *Comply with the requirements of the Treasury State Agreement by drawing federal funds for Low-Income Home Energy Assistance program warrants on a five-day clearance pattern.*

Excess Cash

Contrary to federal regulations, the department carried excess federal cash during the audit period for multiple federal programs. Additionally, department internal controls were not sufficient to prevent such instances of excess cash.

We analyzed cash balances for the department's Supplemental Nutrition Program for Women, Infants, and Children (WIC) and Child Support Enforcement (CSE)

programs for the period under audit and noted significant time periods when the department carried excess federal cash.

For the WIC program, we noted 10 instances of excess federal cash for time periods spanning between 2 and 19 days. The balance of excess WIC cash ranged from \$1,000 to \$360,000. These instances of excess cash are not related to monthly rebates received for the WIC program, as the department appropriately ceases federal cash draws until the program rebates have been used. Department staff claim most of the instances of WIC excess cash in question were times when extra cash was drawn in anticipation of a federal government shutdown. However, absent express permission from the federal government, the department is not permitted to draw in advance for the WIC program.

For the CSE program, the department draws federal funds for the program, and also receives nonfederal cash collections. The nonfederal cash collections are mainly comprised of child support payments from the absent parent, which are sent to the custodial parent within 2 days. During the audit, we noted nearly 50 instances of excess federal cash. Excess cash ranged from \$1,000 to \$525,000, and the overage often lasted for more than a week. Department staff indicate the nonfederal cash collections from the previous day are considered in its calculation of the CSE federal draw. However, by the time the federal funds are received, the department generally collects additional nonfederal funds, which results in a positive cash balance in the CSE account. The department should consider modifying its calculation for the CSE federal draw to accommodate for the nonfederal cash collections.

RECOMMENDATION #24

We recommend the Department of Public Health and Human Services:

- A. *Modify procedures for federal cash draws for the Supplemental Nutrition Program for Women, Infants and Children program, to eliminate instances of excess federal cash, as required by federal regulations.*
- B. *Modify the calculation for federal cash draws for the Child Support Enforcement program to take into consideration anticipated cash collections from nonfederal sources, and to eliminate instances of excess federal cash, as required by federal regulations.*
- C. *Comply with federal regulations to minimize the time between the drawdown of cash for the federal Supplemental Nutrition Program for Women, Infants, and Children, and Child Support Enforcement programs and disbursement for federal program purposes.*

Significant Negative Cash

The department operated its Foster Care and Child Care Development Fund programs from negative cash positions for most of the audit period.

Based on our analysis of cash balances for the Foster Care and Child Care Development Fund (CCDF) programs, there were only a handful of days during the audit period where cash balances were higher than negative \$20,000. Additional detail is in the table below.

Table 15 Negative Cash Information for Foster Care and CCDF Federal Programs		
Federal Award	Negative Cash in Excess of \$20,000	Timespan for Negative Cash
Foster Care	Average daily cash balance for the Foster Care fund was negative \$1 million.	Maximum negative cash reached negative \$3.3 million at least two times during the audit period.
CCDF	28 instances in FY 2019 ranging from \$20,250 to \$1.9 million.	For FY 2019, average negative cash for one federal special revenue account was \$1.2 million for 342 days.

Source: Compiled by the Legislative Audit Division.

By operating from a negative cash position, the department has effectively subsidized federal program costs using funds from the state's treasury. Although department policy requires staff to initiate a federal cash draw when negative cash reaches \$20,000. However, department staff did not consistently follow the policy for these programs during the audit period.

RECOMMENDATION #25

We recommend the Department of Public Health and Human Services initiate federal cash draws for the Foster Care and Child Care Development Fund programs in accordance with department policy.

ADP Monitoring

For the third consecutive audit, the department has not completed the biennial review of Automated Data Processing (ADP) systems, as required by federal regulations. Additionally, department internal controls did not ensure ADP system reviews were fully documented.

Federal regulations require the department maintain a program for conducting periodic risk analyses to ensure appropriate, cost effective safeguards are incorporated into new and existing information systems used to administer federal programs on behalf of the federal Department of Health and Human Services (HHS). In addition, the department is required to review ADP systems on a biennial basis, evaluating physical and data security operating procedures and personnel practices. Without the required biennial reviews, ADP systems could operate with undetected system inefficiencies and security weaknesses. HHS programs administered by the department include Medicaid, Child Support Enforcement, Foster Care, Adoption, and the Children's Health Insurance programs, which account for over 81 percent of federal program expenditures incurred by the department.

The prior two audit reports contained recommendations the department complete risk analyses and biennial reviews over ADP systems in accordance with federal regulations. During the current audit, we performed a sample of 14 ADP systems from a population of 27 systems used in administering HHS programs. Of the 14 systems, we identified 2 for which a biennial review was not completed. We identified 2 additional systems for which the review occurred, but the review was not fully documented.

The department cites turnover as a contributing factor to incomplete and untimely reviews, and acknowledges the two system reviews which were not fully documented. However, the department contends the two reviews not conducted were completed after our audit test was conducted and within the biennium, as required by federal regulation. The prior ADP security reviews were completed in March and April 2017, while the subsequent reviews were completed in November 2019. Because more than two years passed since the completion of each of the prior reviews, the department has not complied with the biennial time frame required.

RECOMMENDATION #26

We recommend the Department of Public Health and Human Services establish and maintain internal controls to ensure Automated Data Processing system reviews are completed and fully documented on a biennial basis, as required by federal regulations.

Accounting Errors

Department controls did not prevent, or detect and correct, a nearly \$32 million overstatement in Construction Work in Process in a timely manner.

During the audit, we reviewed balances recorded to the Construction Work in Process (CWIP) account on the department's accounting records. State policy requires the CWIP account be used to accumulate capitalizable costs at year-end when the associated project is not yet complete. Later, when the capital asset is placed into service, state accounting policy requires the CWIP balances be removed from the accounting records. Because department control procedures were isolated to review of activity in the current year, the department did not identify and remove CWIP balances recorded in previous years for all capital assets placed in service. Department staff also incorrectly believed changes in the asset management module of the state's accounting system would automatically update the CWIP balances in the general ledger. Instead, state accounting policy requires specific manual entries be made to properly reflect CWIP balances in the general ledger.

As summarized in Table 16 below, the department's CWIP balances were overstated at both fiscal year-end 2018 and 2019 by nearly \$32 million dollars, in total, between the state's General Fund and federal special revenue accounts.

Table 16
Overstated Construction Work in Process Balances
 June 30, 2018 and 2019

	2018	2019
General Fund	\$16,216,618	\$16,216,618
Federal Special Revenue accounts	\$15,180,151	\$15,730,151
Total	\$31,396,770	\$31,946,770

Source: Compiled by the Legislative Audit Division.

As part of our review, we noted several projects with balances essentially unchanged since 2012. Because our review was limited to the General Fund and department federal special revenue accounts, additional CWIP errors could exist for other fund types.

RECOMMENDATION #27

We recommend the Department of Public Health and Human Services:

- A. *Conduct and document a thorough review of Construction Work in Process balances for all fund types, and make corrections to the state accounting records as appropriate.*
- B. *Develop and implement internal controls to ensure Construction Work in Process balances are properly removed from the state's accounting records when assets are capitalized, in accordance with state accounting policy.*

Auditing Process and Auditing Standards

As part of our financial-compliance audits, we determine whether department activities are properly recorded to the state's accounting records and subsequently reported in the department's financial schedules. We also determine the department's compliance with state and federal laws and regulations. We conduct our audit work in accordance with *Government Auditing Standards*, issued by the Comptroller General of the United States, and the American Institute of Certified Public Accountants' (AICPA) Statements on Auditing Standards, more commonly known as Generally Accepted Auditing Standards. In addition to these standards, we also conduct our federal compliance work in accordance with the Single Audit Act Amendments of 1996; the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards; and the federal Office of Management and Budget's (OMB) Compliance Supplement.

Auditing Standards

Generally Accepted Auditing Standards (GAAS) require us to obtain sufficient and appropriate audit evidence to draw reasonable conclusions on which to base our opinion. Audit evidence is information we use to support conclusions on which our opinion is based. Audit evidence is cumulative in nature and is primarily obtained from audit procedures performed during the audit. Absence of information to support department actions also constitutes audit evidence.

GAAS defines the following:

- ◆ Appropriateness (of audit evidence): The measure of the quality of audit evidence; that is, its relevance and reliability in providing support for the conclusions on which the auditor's opinion is based.
- ◆ Sufficiency (of audit evidence): The measure of the quantity of audit evidence. The quantity of the audit evidence needed is affected by the auditor's assessment of the risks of material misstatement or noncompliance and also by the quality of such audit evidence.

GAAS further requires us to design and perform audit procedures that are appropriate in the circumstances for the purpose of obtaining sufficient appropriate audit evidence.

Audit Evidence

When evaluating the information to be used as audit evidence, we must consider the relevance and reliability of the information to be used. When information is produced by the entity under audit, we evaluate whether the information is sufficiently reliable for our purposes, including, obtaining audit evidence about the accuracy

and completeness of the information and in evaluating whether the information is sufficiently precise and detailed for our purposes. When audit evidence obtained from one source is inconsistent with that obtained from another, or, when we have doubts about the reliability of information to be used as audit evidence, we determine what modifications or additions to audit procedures are necessary to resolve the matter and consider its effect on other aspects of the audit.

Procedures to obtain audit evidence can include inquiry, inspection, observation, confirmation, recalculation, reperformance, and analytical procedures. Inquiry consists of seeking information of knowledgeable persons, and can be formal written requests or informal oral discussion. Although inquiry may provide important audit evidence, inquiry alone ordinarily does not provide sufficient audit evidence. Rather, results of inquiry must be paired with corroborating audit evidence obtained from other methods.

Just as an agency's records alone may not provide sufficient appropriate audit evidence on which to base an audit opinion on the financial statements, an agency's records alone may not provide sufficient appropriate audit evidence on which to conclude on an agency's compliance with federal program requirements and applicable federal regulations. As a common part of our work and as a generally accepted industry practice, we can obtain more assurance from various sources which corroborate the information obtained from the agency.

Audit Evidence and Consideration of a Scope Limitation

Restrictions on the scope of the audit, whether imposed by the client or by circumstances, such as an inability to obtain sufficient appropriate audit evidence or an inadequacy in the client's records, may require us to qualify our opinion or to disclaim an opinion. A qualified opinion is a statement in our audit report which indicates the information provided by the agency was limited in scope or there was a material issue with regard to the application of accounting principles or compliance requirements, but that such issues are not pervasive. A disclaimer of opinion is a statement in our audit report which indicates no opinion is being given with regard to the application of accounting principles or compliance requirements. A disclaimer, or absence of an audit opinion, is issued when we conclude the possible effects of a scope limitation could be both material and pervasive.

Audit Sampling

Audit sampling is defined as the selection and evaluation of less than 100 percent of the population. When we conduct a sample, we take steps to ensure the items selected are representative of the population, so sample results provide a reasonable basis for

conclusions about the population as a whole. According to the AICPA's *Government Auditing Standards* and Single Audits audit guide, the size of the population has little or no effect on the determination of the sample size, except in relatively small populations of 250 or fewer items. The AICPA Guide also provides additional guidance on sample sizes, confidence levels, tolerable rates of deviation, and error/exception rates which we consider in developing a compliance sample for a federal program. Audits performed for federal programs must adhere to the AICPA standards.

Federal Single Audit Act

The Single Audit Act Amendments of 1996 and the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance) require us to issue certain financial, internal control, and compliance reports in addition to those reports required by *Government Auditing Standards*. The Legislative Audit Division issues a statewide biennial Single Audit Report which complies with the above reporting requirements. The Single Audit Report for the two fiscal years ended June 30, 2019, will be issued by March 31, 2020. Work conducted as part of the Department of Public Health and Human Services's (department) audit will be included in the Single Audit report.

The OMB issues the annual Compliance Supplement which identifies existing compliance requirements that the Federal Government expects to be considered as part of a Single Audit. Without the Compliance Supplement, we would need to research many laws and regulations for each program under audit to determine which compliance requirements could have both a direct and material effect on each federal program. The Compliance Supplement provides one source of information for us to understand the Federal program's objectives, procedures, and compliance requirements relevant to the audit as well as audit objectives and suggested audit procedures for determining compliance with these requirements.

Use of the Compliance Supplement is mandatory. As such, adherence to the Compliance Supplement satisfies the audit requirements under federal Uniform Guidance. Suggested audit procedures in the Compliance Supplement were written to be able to apply to many different programs administered by many different entities, and as such, they are necessarily general in nature. We must use our professional judgment to determine whether suggested audit procedures are sufficient to achieve the stated audit objectives or whether alternative audit procedures are needed.

Medicaid and Children's Health Insurance Program (CHIP) Eligibility Sample

Recommendation #1 beginning on page 12 discusses the results of audit tests to determine whether individuals were appropriately denied or determined eligible for Medicaid and CHIP benefits based on eligibility criteria outlined in federal regulations and the respective state plans. The following sections further discuss specifics related to the Medicaid and CHIP programs, as well as our audit methodologies in reaching our audit conclusions.

Background

Medicaid is a joint federal and state program that, together with the CHIP, provides health coverage to individuals. Federal law requires states to provide services to mandatory coverage groups including the aged, blind, disabled, and low-income parents and children. Eligibility for the aged, blind, and disabled groups is verified at application. The Patient Protection and Affordable Care Act (ACA), enacted in 2010, created an opportunity for states to expand Medicaid to cover nearly all low-income Americans under age 65. In 2015, the legislature substantially changed Montana Medicaid with the passage of the Montana Health and Economic Livelihood Partnership (HELP) Act, essentially expanding Medicaid coverage as permitted under ACA. As such, the state administers Medicaid to both ACA eligible and non-ACA (or traditional) eligible groups. ACA eligibility is based on Modified Adjusted Gross Income (MAGI), which considers taxable income, tax filing status, and family relationships to determine financial eligibility for Medicaid.

The ACA mandated many changes to recipient eligibility policies and processes for Medicaid. The ACA replaced complex income-counting for determining financial eligibility with a more streamlined approach using MAGI, which is a more consistent standard that considers taxable income. Another significant change as a result of the ACA was moving away from in-person and documentation-reliant enrollment processes toward online applications and electronic data checks. Together, these changes shifted much of the responsibility for demonstrating eligibility for the MAGI-based portion of the Medicaid program from individuals to the state.

ACA allows states considerable flexibility in structuring their Medicaid programs within broad federal parameters, including some aspects of program integrity controls. One area in which states have flexibility is in making decisions on certain eligibility verification policies and processes. In Montana, the eligibility verification processes differ between MAGI-based groups and non-MAGI-based groups. For example, income must be verified at application and individuals are subject to certain resource

limits in non-MAGI-based eligibility groups. However, for the MAGI-based groups, Montana has chosen to delay the eligibility verification process for 90 days, and to accept applications received from the federal marketplace at face value without verifying income information.

In April 2019, the Comptroller General of the United States and representatives from the National State Auditors Association sent a letter to the federal Centers for Medicare & Medicaid Services (CMS) requesting changes to the Compliance Supplement to leverage state auditors' ability to examine key areas of Medicaid, including improvements in the oversight of Medicaid eligibility processes. As a result, the 2019 Compliance Supplement for the Medicaid Cluster requires us, "to redetermine eligibility to ensure beneficiaries qualify for the Medicaid program and are in the appropriate enrollment category." Additionally, the 2019 Compliance Supplement for the CHIP program requires us "to test eligibility determinations," which include the application of MAGI and household definition eligibility criteria. One of the objectives for the eligibility compliance requirement, per the Compliance Supplement, includes determining whether only eligible individuals or groups of individuals participated in the federal program.

A new Compliance Supplement is published annually. Draft modifications for the 2020 Compliance Supplement were released in February 2020. The draft 2020 Compliance Supplement indicates, "For States that accept applicant self-attestation for certain factors of eligibility such as household composition, and do not require further verification or documentation, the auditors are not expected to test beyond the requirements of the state." The draft 2020 Compliance Supplement does not prohibit auditors from establishing scope to consider additional information as audit evidence. The 2019 Montana Legislature passed revisions to state law which require the department to verify eligibility using allowed data sources at application. Changes to state law also provide the department access to state taxpayer return information for purposes of verifying the income reported by applicants for medical assistance. Because these changes will affect our next federal compliance testing cycle (fiscal years 2020 and 2021), we will have an opportunity to monitor how the department implements these new provisions.

Audit Scope

We established audit scope for the Medicaid and CHIP programs by considering the inherent risk factors associated with the programs, by gaining an understanding of the department's internal control over Medicaid and CHIP eligibility, and finally by developing audit procedures necessary to support our opinion over the department's compliance with the applicable state plans and federal compliance requirements.

Internal Control Considerations

As summarized in Recommendation #1, the department's internal control is not sufficiently designed to identify and remove participants from the Medicaid or CHIP programs when participants misrepresent their household composition, sources of income, and residency in order to circumvent the programs' eligibility requirements. We also observed situations where the department had evidence that a program participant was ineligible, but the department allowed them to remain in the program. Specifically, we observed evidence of the following internal control deficiencies over eligibility determinations:

- ◆ Instances in which the interfaces between information in the department's records with external data sources did not run.
- ◆ Instances when required redeterminations of eligibility did not occur.
- ◆ Instances where the department received evidence of discrepancies in eligibility criteria which were not followed up on.
- ◆ Instances where department staff overrode information system controls to allow ineligible individuals to remain in the Medicaid or CHIP programs.

At the time of application, the department accepts self-attested answers related to critical eligibility factors, including income and household size. While self-attestation is required by ACA, successful implementation of all Medicaid and CHIP eligibility requirements requires rigorous application of internal controls, many of which are dependent on system-based verifications and secondary data sources.

Based on federal guidance, federal tax filer status, household size, and income are all critical factors for MAGI-based determinations. The department's verification plan which applies to MAGI-based eligibility groups specifically excludes tax information as a data source for eligibility determinations despite the fact that tax data is the basis for such determinations under federal regulations.

For the aforementioned reasons, we concluded internal controls, as designed, are likely to be ineffective in preventing ineligible individuals from being determined eligible under the department's processes.

Scope for Compliance Testing

As described above, we concluded the department's internal control policies and procedures were not adequately designed to ensure only individuals who meet eligibility criteria outlined in the Medicaid and CHIP state plans were determined eligible and placed into the proper eligibility group. In such cases, auditing standards require us to expand our tests of compliance.

As mentioned previously, the department has chosen to accept self-attested information for certain eligibility criteria, including income. In combination with inconsistencies in timely and complete data information matches for both enrollment and redetermination, we considered the relevance and reliability of information to which we would have access using only the department's records. We concluded that limiting our review to information in the department's records would not provide sufficient and appropriate audit evidence on which to base our conclusion over the department's compliance with federal eligibility requirements for the Medicaid and CHIP programs.

The inadequacies in the department's Medicaid and CHIP client records is considered a restriction on the scope of the audit. By using only that data source we were unable to obtain sufficient appropriate audit evidence to support a conclusion over compliance. When a scope limitation is unresolved, auditing standards direct us to qualify our opinion or to disclaim an opinion on compliance. Our decision to qualify or disclaim an opinion because of a scope limitation depends on our assessment of the importance of the omitted procedures in relation to our ability to form an opinion on compliance with requirements governing each major federal program. We are aware that auditors of other states have disclaimed an opinion on compliance with Medicaid eligibility requirements, and as a result, those auditors have questioned all federal cost of the Medicaid program. Based on our observations of internal control deficiencies over Medicaid and CHIP eligibility determinations, at this point in the audit we had enough evidence to disclaim an opinion, and we considered whether this approach was most beneficial for our audit.

To avoid questioning over \$4.02 billion in federal costs for the Medicaid and CHIP programs that would result from a disclaimer of opinion, we considered whether a third-party data source was available. State law allows us access to state tax records, a data source we consider relevant to both affirm the reliability of information in the department's eligibility records and as the basis for redetermining eligibility in accordance with requirements in the State Plans using MAGI information. We chose to conduct a statistical sample as a means of testing eligibility, using state tax data.

Sampling Plan and Results

To test eligibility for our sample, we focused on household size, income, and residency eligibility factors:

- ◆ **Household Size:** For the MAGI-based groups, the use of tax filer status is critical because it drives whether the department should use CMS "tax filer rules" or "non-tax filer rules" to determine household size. Household size is critical because it sets the allowable income level for both MAGI-based and non-MAGI-based applicants.

- ♦ **Income:** For MAGI-based groups, MAGI information available on tax records is the basis for income eligibility determinations, while certain individuals may qualify for Medicaid regardless of income, for some non-MAGI-based eligibility categories, income remains a key eligibility factor.
- ♦ **Residency:** In order to qualify for Montana's Medicaid or CHIP programs, an individual must reside within the state's boundaries. State tax data includes evidence which supports state residency status.

For these eligibility factors, we used state tax data for two purposes: 1) to affirm the reliability of information in the department's eligibility records; and, 2) to redetermine eligibility in accordance with federal laws, regulations, and the requirements in the State Plans using MAGI information.

We sampled from a population of 571,862 determinations, which included unduplicated eligibility determinations for individuals. If an individual's Medicaid or CHIP eligibility was stopped, or if an individual changed eligibility groups during the audit period, the individual may have been included in the population more than one time. We selected an initial sample size of 188 individuals for testing. However, based on the results of sample testing for the first 63 individual case files, we determined the likelihood of identifying additional eligibility determination errors was significant. We considered sampling guidance for federal compliance purposes, which indicates a sample size of 60 items is appropriate in situations when we desire a high level of assurance to address the risk of material noncompliance. As such, because the first 63 items already provided us with sufficient and appropriate audit evidence to support our opinion over the department's compliance with federal regulations applicable to Medicaid and CHIP eligibility determinations, we determined it neither efficient nor necessary to continue testing the remaining sample population.

We believe the evidence obtained provides a reasonable basis for our findings and conclusions which are further discussed beginning on page 12.

Independent Auditor's Report and Department Financial Schedules

LEGISLATIVE AUDIT DIVISION

Angus Maciver, Legislative Auditor
 Deborah F. Butler, Legal Counsel



Deputy Legislative Auditors:
 Cindy Jorgenson
 Joe Murray

INDEPENDENT AUDITOR'S REPORT

The Legislative Audit Committee
 of the Montana State Legislature:

Introduction

We have audited the accompanying Schedules of Changes in Fund Equity & Property Held in Trust, Schedules of Total Revenues & Transfers-In, and Schedules of Total Expenditures & Transfers-Out of the Department of Public Health and Human Services for each of the fiscal years ended June 30, 2019, and 2018, and the related notes to the financial schedules.

Management's Responsibility for the Financial Schedules

Management is responsible for the preparation and fair presentation of these financial schedules in accordance with the regulatory format prescribed by the Legislative Audit Committee, based on the transactions posted to the state's accounting system without adjustment; this responsibility includes recording transactions in accordance with state accounting policy; and designing, implementing, and maintaining internal controls relevant to the preparation and fair presentation of the financial schedules that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express opinions on these financial schedules based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial schedules are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial schedules. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial schedules, whether due to fraud or error. In making those risk assessments, the auditor considers internal controls relevant to the department's preparation and fair presentation of the financial schedules in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the department's internal control, and accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness

of significant accounting estimates made by management, as well as the overall presentation of the financial schedules.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Basis for Adverse Opinions on U.S. Generally Accepted Accounting Principles

As described in Note 1, the financial schedules are prepared from the transactions posted to the state's primary accounting system without adjustment, in the regulatory format prescribed by the Legislative Audit Committee. This is a basis of accounting other than accounting principles generally accepted in the United States of America. The financial schedules are not intended to, and do not, report assets, liabilities, and cash flows.

The effects on the financial schedules of the variances between the regulatory basis of accounting described in Note 1 and accounting principles generally accepted in the United States of America, although not reasonably determinable, are presumed to be material.

Adverse Opinions on U.S. Generally Accepted Accounting Principles

In our opinion, because of the significance of the matter discussed in the "Basis for Adverse Opinions on U.S. Generally Accepted Accounting Principles" paragraph, the financial schedules referred to above do not present fairly, in accordance with accounting principles generally accepted in the United States of America, the financial position of the department as of June 30, 2019, and June 30, 2018, or changes in financial position or cash flows for the years then ended.

Basis for Qualified Opinions on Regulatory Basis of Accounting

The financial schedules do not disclose a loss contingency related to questioned costs between \$84,000,000 and \$163,100,000 of payments made to recipients who may not be eligible for the Medicaid and Children's Health Insurance Program for fiscal years 2018 and 2019. The associated federal findings will be submitted to the Federal Audit Clearinghouse by March 31, 2020, as part of the State of Montana's Single Audit Report. Once submitted, the federal grantor agency is responsible for issuing a management decision regarding the findings and any expected repayment of disallowed costs.

Accounting principles generally accepted in the United States of America require a loss contingency of this magnitude be disclosed. The questioned costs represent a range of costs paid by the federal government which it could disallow, requiring the state to return the federal share. While a contingency is a future event or circumstance which is possible but cannot be predicted with certainty, the likelihood of loss of this contingency is more than remote and therefore disclosure is required.

Qualified Opinions on Regulatory Basis of Accounting

In our opinion, except for the omission of the information described in the “Basis for Qualified Opinions” paragraph, the financial schedules referred to above present fairly, in all material respects, the results of operations and changes in fund equity and property held in trust of the Department of Public Health and Human Services for each of the fiscal years ended June 30, 2019, and 2018, in conformity with the basis of accounting described in Note 1.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated January 21, 2020, on our consideration of the Department of Public Health and Human Services’ internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the department’s control over financial reporting and compliance.

Respectfully submitted,

/s/ Cindy Jorgenson

Cindy Jorgenson, CPA
Deputy Legislative Auditor
Helena, MT

January 21, 2020

PUBLIC HEALTH & HUMAN SERVICES
SCHEDULE OF CHANGES IN FUND EQUITY & PROPERTY HELD IN TRUST
FOR THE FISCAL YEAR ENDED JUNE 30, 2019

	General Fund	State Special Revenue Fund	Federal Special Revenue Fund	Debt Service Fund	Capital Projects Fund	Agency Fund	Permanent Fund
	\$ <u>(37,715,928)</u>	\$ <u>41,234,890</u>	\$ <u>(1,352,010)</u>	\$ <u>3,068,971</u>	\$ <u>(4,517)</u>	\$ <u>1,784,185</u>	\$ <u>228,718,800</u>
ADDITIONS							
Budgeted Revenues & Transfers-In	28,833,856	50,089,700	2,072,027,830	2,690,762			40,963
Nonbudgeted Revenues & Transfers-In	11,293	5,636,337	891,695				29,740,692
Prior Year Revenues & Transfers-In Adjustments	8,352	(332,411)	(65,224,814)				(630)
Direct Entries to Fund Equity	499,896,185	122,655,228	(1,651,644)				
Additions to Property Held in Trust							
Total Additions	<u>528,749,686</u>	<u>178,068,854</u>	<u>2,006,043,066</u>	<u>2,690,762</u>	<u>2,690,762</u>	<u>929,363</u>	<u>76,941,344</u>
REDUCTIONS							
Budgeted Expenditures & Transfers-Out	545,428,407	167,531,199	2,099,065,658	1,302,468		1,401,534	7,757,024
Nonbudgeted Expenditures & Transfers-Out	43,377	9,019,631	(14,499)				
Prior Year Expenditures & Transfers-Out Adjustments	(9,759,180)	(1,683,020)	(67,711,146)				
Reductions in Property Held in Trust							
Total Reductions	<u>535,712,604</u>	<u>174,867,809</u>	<u>2,031,340,013</u>	<u>1,302,468</u>	<u>1,302,468</u>	<u>1,401,534</u>	<u>76,772,973</u>
FUND EQUITY: June 30, 2019							
PROPERTY HELD IN TRUST: June 30, 2019	\$ <u>(44,678,846)</u>	\$ <u>44,435,934</u>	\$ <u>(26,649,957)</u>	\$ <u>4,457,264</u>	\$ <u>(476,688)</u>	\$ <u>4,457,264</u>	\$ <u>1,952,556</u>

This schedule is prepared from the Statewide Accounting, Budgeting, and Human Resources System (SABHRS) without adjustment. Additional information is provided in the notes to the financial schedules beginning on page A-11.

PUBLIC HEALTH & HUMAN SERVICES
SCHEDULE OF CHANGES IN FUND EQUITY & PROPERTY HELD IN TRUST
FOR THE FISCAL YEAR ENDED JUNE 30, 2018

	General Fund	State Special Revenue Fund	Federal Special Revenue Fund	Debt Service Fund	Capital Projects Fund	Agency Fund	Permanent Fund
FUND EQUITY: July 1, 2017	\$ (35,560,528)	\$ 32,593,526	\$ (3,483,518)	\$ 3,203,957	\$ (98,787)	\$ 1,209,730	\$ 223,397,885
PROPERTY HELD IN TRUST: July 1, 2017							
ADDITIONS							
Budgeted Revenues & Transfers-In	26,705,323	49,356,827	2,038,007,353				38,411
Nonbudgeted Revenues & Transfers-In	844	6,664,967	838,636				11,473,762
Prior Year Revenues & Transfers-In Adjustments	2,044,009	(647,034)	(36,909,136)				(1,084)
Direct Entries to Fund Equity	489,652,562	119,480,087	68,598				
Total Additions	518,402,738	174,854,847	2,002,005,452	1,839,627	322,541	77,875,229	11,511,089
REDUCTIONS							
Budgeted Expenditures & Transfers-Out	532,499,491	156,669,214	2,037,661,054				228,271
Nonbudgeted Expenditures & Transfers-Out	(191,258)	10,356,481	(7,093)				7,258,867
Prior Year Expenditures & Transfers-Out Adjustments	(11,750,095)	(812,212)	(37,779,017)				(1,068,693)
Reductions in Property Held in Trust							
Total Reductions	520,558,138	166,213,483	1,999,874,944	1,974,613	228,271	77,300,774	6,190,174
FUND EQUITY: June 30, 2018	\$ (37,715,928)	\$ 41,234,890	\$ (1,353,010)	\$ 3,068,971	\$ (4,517)	\$ 1,0	\$ 228,718,800
PROPERTY HELD IN TRUST: June 30, 2018							

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PUBLIC HEALTH & HUMAN SERVICES
SCHEDULE OF TOTAL REVENUES & TRANSFERS-IN
FOR THE FISCAL YEAR ENDED JUNE 30, 2019

TOTAL REVENUES & TRANSFERS-IN BY CLASS		General Fund	State Special Revenue Fund	Federal Special Revenue Fund	Debt Service Fund	Capital Projects Fund	Permanent Fund	Total
Licenses and Permits		\$ 88,749	\$ 3,495,159					\$ 3,583,908
Taxes		\$ 4,350,175						4,350,175
Charges for Services		\$ 15,995,764	\$ 18,136,866	\$ (105,822)	\$ 1,394,276			34,026,808
Investment Earnings			263,943		1,010,826			19,637,564
Fines and Forfeits		6,511		5,023,943				1,010,826
Monetary Settlements								31,823,573
Rental, Leases and Royalties								98,781
Contributions and Premiums								56,027
Grants, Contracts, and Donations								5,838,969
Transfers-in								9,099,875
Capital Asset Sale Proceeds								14,874,701
Inception of Lease/Installment Contract								21,912
Federal Indirect Cost Recoveries								29,884
Miscellaneous								80,743,458
Federal								1,456,441
Total Revenues & Transfers-in		\$ 28,853,501						1,917,780,720
Less: Nonbudgeted Revenues & Transfers-in								2,124,433,623
Prior Year Revenues & Transfers-in Adjustments								38,990,779
Actual Budgeted Revenues & Transfers-in								(65,549,504)
Estimated Revenues & Transfers-in								2,150,992,348
Budgeted Revenues & Transfers-in Over (Under) Estimated								2,154,998,740
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BUDGETED REVENUES & TRANSFERS-IN OVER (UNDER) ESTIMATED BY CLASS								
Licenses and Permits			\$ (1)					\$ (1)
Taxes		\$ (600)						(600)
Charges for Services		\$ 1,368						(135,604)
Investment Earnings			(53,477)					(53,479)
Monetary Settlements								(3,563)
Rental, Leases and Royalties								(1,485)
Contributions and Premiums								(2)
Grants, Contracts, and Donations								756,913
Transfers-in								(198,391)
Federal Indirect Cost Recoveries								14,757
Miscellaneous								(4,384,906)
Budgeted Revenues & Transfers-in Over (Under) Estimated		\$ 28,118						\$ 0
								\$ (4,006,392)
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PUBLIC HEALTH & HUMAN SERVICES
 SCHEDULE OF TOTAL REVENUES & TRANSFERS-IN
 FOR THE FISCAL YEAR ENDED JUNE 30, 2018

	General Fund		State Special Revenue Fund		Federal Special Revenue Fund		Debt Service Fund		Permanent Fund		Total
	General Fund	State Special Revenue Fund	General Fund	State Special Revenue Fund	General Fund	State Special Revenue Fund	General Fund	State Special Revenue Fund	General Fund	State Special Revenue Fund	
TOTAL REVENUES & TRANSFERS-IN BY CLASS											
Licenses and Permits	\$ 90,289	\$ 1,820,175									\$ 1,910,464
Taxes	4,350,775										4,350,775
Charges for Services	15,802,751	\$ 17,862,891	\$ (133,422)		\$ 177,968		\$ 684,579				33,532,220
Investment Earnings	266,054	126,949			1,730,413						1,255,150
Fines and Forfeits					3,963,609						1,730,413
Monetary Settlements											28,411,736
Sale of Documents, Merchandise and Property	16,171	14,331,333									103,696
Rentals, Leases and Royalties	3,236	100,459									48,358
Contributions and Premiums	56	48,302									5,231,657
Grants, Contracts, and Donations	5,231,657	11,896,257									11,914,257
Transfers-in		6,466,426			2,739,820						14,526,131
Federal Indirect Cost Recoveries	2,932,338	61,784			66,545,597						66,607,381
Miscellaneous	20,262	125,959			499,121						645,342
Federal	36,585	2,534,225			1,926,573,715						1,929,144,526
Total Revenues & Transfers-in	28,750,176	55,374,761			2,001,936,854						2,099,412,506
Less: Nonbudgeted Revenues & Transfers-in	844	6,664,967			838,636						20,817,836
Prior Year Revenues & Transfers-in Adjustments		(647,034)			(36,909,136)						(35,513,245)
Actual Budgeted Revenues & Transfers-in	26,705,323	49,356,827			2,038,007,353		0				38,411
Estimated Revenues & Transfers-in	28,479,020	48,938,525			2,008,679,983						40,000
Budgeted Revenues & Transfers-in Over (Under) Estimated	\$ (1,773,697)	\$ 418,302			\$ 29,327,370		\$ 0				\$ (1,589)
BUDGETED REVENUES & TRANSFERS-IN OVER (UNDER) ESTIMATED BY CLASS											
Licenses and Permits	\$ 13,289	\$ 369,661			(208,450)						\$ 382,950
Charges for Services	(2,044,957)	(1,392,651)	\$								(3,646,058)
Investment Earnings	206,054	(125,524)									78,942
Fines and Forfeits					1,680,413						1,680,413
Monetary Settlements					313,608						1,312,251
Sale of Documents, Merchandise and Property	16,171	982,472	(227)								(9,192)
Rentals, Leases and Royalties	(764)	(7,698)									155,311
Grants, Contracts, and Donations	(1,494)	155,311									1,529,046
Transfers-in		221,283									3,384,590
Federal Indirect Cost Recoveries					1,307,762						(710,635)
Miscellaneous					3,384,590						23,813,757
Federal					(530,345)						\$ 27,970,386
Budgeted Revenues & Transfers-In Over (Under) Estimated	\$ (1,773,697)	\$ 418,302			\$ 29,327,370		\$ 0				\$ (1,589)

This schedule is prepared from the Statewide Accounting, Budgeting, and Human Resources System (SABHRS) without adjustment. Additional information is provided in the notes to the financial schedules beginning on page A-11.

PUBLIC HEALTH & HUMAN SERVICES
SCHEDULE OF TOTAL EXPENDITURES & TRANSFERS-OUT
FOR THE FISCAL YEAR ENDED JUNE 30, 2019

PROGRAM (ORG) EXPENDITURES & TRANSFERS-OUT	Addictive & Mental Disorders	Business & Financial Services	Child & Family Services	Child Support Enforcement	Developmental Services Division	Director's Office	Disability Employment & Transitions	Health Resources Division	Human and Community Services	Management & Fair Hearings	Medicaid & Health Services Management	Public Health & Safety Division	Quality Assurance Division	Senior & Long Term Care Services	Technology Services Division	Total	
Personal Services																	
Salaries	\$ 30,918,286	\$ 2,322,630	\$ 18,934,017	\$ 6,049,041	\$ 7,283,803	\$ 5,903,152	\$ 5,313,628	\$ 2,025,513	\$ 19,359,025	\$ 1,919,869	\$ 766,426	\$ 11,458,933	\$ 5,184,468	\$ 8,825,169	\$ 4,301,157	\$ 130,565,117	
Employee Benefits	15,626,184	1,023,555	8,750,483	2,590,806	3,380,489	1,811,123	2,389,308	801,641	9,230,360	714,766	229,283	4,634,732	2,251,489	4,539,056	1,584,138	59,557,413	
Total	46,544,470	3,346,185	27,684,500	8,639,847	10,664,292	7,714,275	7,702,937	2,827,154	28,589,385	2,634,635	995,709	16,093,664	7,435,958	13,364,225	5,885,296	190,122,530	
Operating Expenses																	
Other Services	18,516,319	4,332,802	2,505,302	300,799	2,960,697	1,477,462	2,579,509	10,663,603	6,688,304	109,034	17,916,190	8,924,353	1,593,938	5,892,734	59,317,691	143,778,737	
Supplies & Materials	4,122,609	48,689	216,325	56,693	207,380	214,997	167,016	15,626	328,264	13,866	463	1,847,742	82,617	1,266,793	2,772,703	11,361,781	
Communications	114,913	1,379,942	443,043	271,748	32,601	8,763	242,315	6,567	451,123	9,530	1,375	661,260	110,182	65,141	4,770,431	8,568,936	
Travel	264,737	1,204	764,849	12,813	34,456	113,780	117,306	10,716	358,720	7,131	10,472	783,204	352,748	116,209	16,010	2,964,355	
Rent	2,114,721	1,913,724	3,164,951	752,287	312,884	53,805	901,840	7,218	2,468,110	117,719	7,999	110,553	595,307	462,897	290,101	13,274,115	
Utilities	748,950	186	1,206		245,606			317	11,852			13,819		134,458		1,156,393	
Repair & Maintenance	874,563	9,266	89,333	20,784	274,978	49,124	338,404	532	125,636	1,731		325,997	27,959	216,062	1,418,107	3,772,477	
Other Expenses	4,962,032	(10,064,914)	8,466,577	6,504,592	2,801,184	(7,929,267)	1,165,232	22,394,418	12,924,910	(2,847,964)	(9,637,996)	5,344,498	406,892	2,786,835	(27,954,381)	9,322,648	
Goods Purchased For Resale	79,614															79,614	
Total	31,798,457	(2,379,101)	15,651,587	7,919,715	6,869,786	(6,011,338)	5,511,622	33,098,996	23,356,919	(2,588,952)	8,298,503	18,011,427	3,169,642	10,941,131	40,630,662	194,279,056	
Equipment & Intangible Assets																	
Equipment	585,330								1,190			470,682				82,609	
Capital leases - equipment		29,884														29,884	
Total	585,330	29,884							1,190			470,682				82,609	
Local Assistance																	
From State Sources	1,940,641															1,940,641	
Total	1,940,641															1,940,641	
Grants																	
From State Sources	1,974,457	232			(174,500)											6,035,083	
From Federal Sources	6,846,628		8,112,653		132,550				22,672,320			885,172	20,545,815	859,278	8,208,582	12,819,406	
From Other Sources													1,118,627			68,262,998	
Grant To Governmental Entities													678,130			1,118,627	
Total	8,821,085		8,112,885		(41,950)				22,672,320			885,172	27,326,706	859,278	14,243,665	82,879,161	
Benefits & Claims																	
To Individuals	102,237,689		53,669,042		255,590,021			8,877,898	1,305,134,490	77,584,672		17,272	3,306,270		291,298,295	2,097,715,649	
From Federal Sources								8,877,898	1,305,134,490	159,759,436			6,351,323			166,110,759	
Total	102,237,689		53,669,042		255,590,021			8,877,898	1,305,134,490	237,344,109			17,272	9,657,593			2,263,826,409
Transfers-out																	
Fund transfers	1,424,986	7,757,024	214,900		689,039	222,050	772,448	2,657,460			6,576	337,647	49,094	2,455,661		16,586,884	
Total	1,424,986	7,757,024	214,900		689,039	222,050	772,448	2,657,460			6,576	337,647	49,094	2,455,661		16,586,884	
Debt Service																	
Bonds	1,302,468															1,302,468	
Loans	161,688															266,781	
Installment Purchases		7,828														7,828	
Total	1,464,156	7,828														1,577,077	
Total Expenditures & Transfers-Out	\$ 194,816,813	\$ 8,761,820	\$ 105,332,915	\$ 16,559,562	\$ 273,162,031	\$ 2,350,026	\$ 22,314,507	\$ 1,341,833,087	\$ 314,621,383	\$ 45,683	\$ 10,203,231	\$ 71,897,720	\$ 11,513,970	\$ 332,370,137	\$ 46,598,567	\$ 2,752,381,453	
EXPENDITURES & TRANSFERS-OUT BY FUND																	
General Fund	\$ 75,029,143	\$ 612,241	\$ 59,257,769	\$ 4,103,153	\$ 81,415,234	\$ 918,998	\$ 5,489,507	\$ 182,171,144	\$ 40,720,020	\$ 14,499	\$ 2,616,384	\$ 4,385,327	\$ 2,460,153	\$ 73,035,683	\$ 3,483,349	\$ 535,712,604	
State Special Revenue Fund	24,316,606	9,932	1,749,808	1,325,608	6,491,255	926,413	899,126	70,296,818	5,419,290	23,470	42	16,525,597	2,886,675	43,865,279	129,889	174,867,809	
Federal Special Revenue Fund	94,168,595	382,623	44,325,338	11,130,801	185,255,542	504,616	15,925,874	1,089,365,125	268,482,073	7,714	7,586,805	50,986,796	6,165,142	215,469,175	41,583,795	2,031,340,013	
Debt Service Fund		1,302,468														1,302,468	
Capital Projects Fund		7,757,024														1,401,534	
Permanent Fund																	

PUBLIC HEALTH & HUMAN SERVICES
SCHEDULE OF TOTAL EXPENDITURES & TRANSFERS-OUT
FOR THE FISCAL YEAR ENDED JUNE 30, 2018

PROGRAM (ORG) EXPENDITURES & TRANSFERS-OUT	Addictive & Mental Disorders	Business & Financial Services	Child & Family Services	Child Support Enforcement	Developmental Services Division	Director's Office	Disability Employment & Transitions	Health Resources Division	Human and Community Services	Management & Fair Hearings	Medicaid & Health Services Management	Public Health & Safety Division	Quality Assurance Division	Senior & Long Term Care Services	Technology Services Division	Total
Personal Services																
Salaries	\$ 32,577,789	\$ 2,398,149	\$ 19,200,842	\$ 6,085,399	\$ 9,524,679	\$ 6,029,906	\$ 5,472,832	\$ 2,267,685	\$ 19,090,271	\$ 1,519,470	\$ 766,577	\$ 10,724,438	\$ 4,443,579	\$ 8,702,551	\$ 4,542,818	\$ 133,346,985
Employee Benefits	14,872,021	894,978	7,938,922	2,352,850	4,088,422	1,616,679	2,199,825	823,258	8,300,227	484,971	205,706	3,952,423	1,742,233	4,030,585	1,520,406	55,023,505
Total	47,449,810	3,293,127	27,139,764	8,438,249	13,613,101	7,646,585	7,672,657	3,090,944	27,390,498	2,004,441	972,283	14,676,861	6,185,813	12,733,136	6,063,223	188,370,489
Operating Expenses																
Other Services	14,883,712	4,422,509	2,985,041	356,074	3,254,718	825,218	2,595,685	14,744,403	3,597,903	58,012	15,682,384	10,236,341	1,221,815	5,019,799	18,417,893	98,301,507
Supplies & Materials	3,676,660	44,815	182,535	54,201	293,712	147,248	184,966	20,512	62,433	8,989	3,271	1,687,108	78,737	1,130,844	2,839,596	10,415,627
Communications	124,376	1,362,643	450,041	317,078	33,667	259,611	197,200	6,075	490,793	8,912	950	752,369	110,939	78,522	4,118,480	8,311,656
Travel	183,736	2,084	761,953	7,142	31,736	90,167	88,316	7,065	230,491	6,825	7,375	720,326	238,993	67,915	14,399	2,458,522
Rent	2,107,373	1,902,516	3,151,309	760,337	303,108	56,409	984,029	9,140	2,790,698	109,477	7,826	56,811	501,681	564,270	289,088	13,594,074
Utilities	770,406		980		287,931				15,670			9,741		137,937	6	1,222,670
Repair & Maintenance	386,369	10,225	71,002	26,162	81,107	89,392	328,797	965	164,488	2,808		350,697	21,952	221,116	744,804	2,499,883
Other Expenses	5,850,688	(10,296,258)	7,744,824	6,342,438	3,311,632	(7,971,833)	1,217,848	20,856,729	12,524,645	(2,317,000)	(9,353,537)	5,067,845	268,160	2,531,278	(25,767,623)	10,009,836
Goods Purchased For Resale	87,258														87,258	
Total	28,070,577	(2,551,465)	15,347,684	7,863,432	7,597,611	(6,503,788)	5,596,842	35,644,889	19,877,120	(2,121,978)	6,348,269	18,881,237	2,442,278	9,751,680	656,645	146,901,033
Equipment & Intangible Assets																
Equipment	8,284						21,547		156,394			519,576				705,802
Total	8,284						21,547		156,394			519,576				705,802
Local Assistance																
From State Sources	2,015,609															2,015,609
Total	2,015,609															2,015,609
Grants																
From State Sources	2,745,450						572,000					3,121,588		5,891,342		12,330,380
From Federal Sources	6,650,272		7,278,156			185,193			23,501,327		2,998,236	17,185,540	568,569	6,833,921		65,201,214
From Other Sources												1,182,715				1,182,715
Grant To Governmental Entities												694,400				694,400
Total	9,395,722		7,278,156			757,193			23,501,327		2,998,236	22,184,243	568,569	12,725,263		79,408,709
Benefits & Claims																
To Individuals	100,493,777		51,528,890		262,613,139		12,412,565	1,304,122,136	81,133,030		3,419	3,968,884		261,144,165		2,077,420,005
From Federal Sources								12,412,565	1,304,122,136	255,046,305			7,402,693		181,315,968	
Total	100,493,777		51,528,890		262,613,139						3,419	11,371,577				2,258,735,974
Transfers-out																
Fund transfers	2,024,636	7,258,867	186,976			130,000	206,424	(314,453)	3,584,693	71,861	675	536,528	146,169	2,923,772		16,756,148
Total	2,024,636	7,258,867	186,976			130,000	206,424	(314,453)	3,584,693	71,861	675	536,528	146,169	2,923,772		16,756,148
Debt Service																
Bonds	1,913,066															1,913,066
Loans	126,208															225,856
Installment Purchases		6,938														6,938
Total	2,039,274	6,938														2,145,861
Total Expenditures & Transfers-Out	\$ 191,497,690	\$ 8,007,468	\$ 101,481,469	\$ 16,301,681	\$ 283,861,783	\$ 2,029,990	\$ 25,910,035	\$ 1,342,543,516	\$ 329,556,337	\$ (45,676)	\$ 10,322,881	\$ 68,170,022	\$ 9,342,828	\$ 299,339,731	\$ 6,719,868	\$ 2,695,039,622
EXPENDITURES & TRANSFERS-OUT BY FUND																
General Fund	\$ 72,042,298	\$ 495,193	\$ 59,438,903	\$ 3,882,447	\$ 86,170,477	\$ 413,658	\$ 8,268,139	\$ 174,669,122	\$ 36,594,964	\$ (101,585)	\$ 3,745,264	\$ 3,896,104	\$ 2,166,551	\$ 67,901,910	\$ 974,693	\$ 520,558,138
State Special Revenue Fund	24,334,084	(4,526)	2,149,678	1,491,027	6,563,529	1,160,131	819,917	67,522,117	5,633,874	4,285	21	17,049,430	1,968,072	37,529,837	(7,996)	166,213,483
Federal Special Revenue Fund	93,146,696	257,934	39,892,888	10,928,206	191,127,777	456,200	16,821,979	1,101,420,970	287,327,499	51,624	6,577,596	47,224,488	5,208,205	193,907,983	5,524,899	1,999,874,944
Debt Service Fund		1,974,613														1,974,613
Capital Projects Fund																228,271
Permanent Fund																228,271
Total Expenditures & Transfers-Out	191,497,690	8,007,468	101,481,469	16,30												

Department of Public Health and Human Services

Notes to the Financial Schedules

For the Two Fiscal Years Ended June 30, 2019

1. Summary of Significant Accounting Policies

Basis of Accounting

The Department of Public Health and Human Services uses the modified accrual basis of accounting, as defined by state accounting policy, for its Governmental fund category (General, State Special Revenue, Federal Special Revenue, Capital Projects, Debt Service, and Permanent). In applying the modified accrual basis, the Department records:

- ♦ Revenues when it receives cash or when receipts are realizable, measurable, earned, and available to pay current period liabilities.
- ♦ Expenditures for valid obligations when the Department incurs the related liability and it is measurable, with the exception of the cost of employees' annual and sick leave. State accounting policy requires the Department to record the cost of employees' annual and sick leave when used or paid.

The Department uses accrual basis accounting for Fiduciary fund categories. Under the accrual basis, as defined by state accounting policy, the Department records revenues in the accounting period when realizable, measurable, and earned, and records expenses in the period incurred when measurable.

Expenditures and expenses may include: entire budgeted service contracts even though the Department receives the services in a subsequent fiscal year; goods ordered with a purchase order before fiscal year-end, but not received as of fiscal year-end; and equipment ordered with a purchase order before fiscal year-end.

Basis of Presentation

The financial schedule format was adopted by the Legislative Audit Committee. The financial schedules are prepared from the transactions posted to the state's accounting system without adjustment.

The Department uses the following funds:

Governmental Fund Category

- ♦ **General Fund** – to account for all financial resources except those required to be accounted for in another fund. The Department uses general fund in each of the programs. General fund is used primarily to provide match for

various federal programs including Medicaid, TANF and IV-E. Additionally, general fund is used to support the Montana State Hospital, the Montana Mental Health Nursing Care Center.

- ◆ **State Special Revenue Fund** – to account for proceeds of specific revenue sources (other than private-purpose trusts or major capital projects) that are legally restricted to expenditures for specific state program purposes. Department State Special Revenue Funds include programs such as Child Support Enforcement, tobacco tax expenditures, Public Health Laboratory, Healthy Montana Kids, medical marijuana license fees, and third-party liability recoveries. The fund also accounts for activity at the Montana Mental Health Nursing Care Center, the Montana Chemical Dependency Center and the Montana State Hospital supported by insurance and individual payments.
- ◆ **Federal Special Revenue Fund** – to account for activities funded from federal revenue sources. Department Federal Special Revenue Funds include federal grants such as Medicaid, Temporary Assistance to Needy Families, Low-Income Home Energy Assistance Program, Weatherization Assistance Program, Vocational Rehabilitation, Child Support Enforcement, Foster Care, Adoption Assistance, Women Infants and Children, Supplemental Nutrition Assistance Program, Child and Adult Nutrition, Children's Health Insurance Plan, Social Service Block Grant, Center for Disease Control, Substance Abuse Prevention and Treatment and Child Care Development Fund Grant programs.
- ◆ **Debt Service Fund** – to account for accumulated resources for the payment of general long-term debt principal and interest. The Department accounts for the Montana State Hospital bond payments in this fund.
- ◆ **Capital Projects Fund** – to account for financial resources used for the acquisition or construction of major capital facilities, other than those financed trust funds. The Department uses this fund for major information technology systems.
- ◆ **Permanent Fund** – to account for financial resources that are permanently restricted to the extent that only earnings, and not principal, may be used for purposes that support the Department's programs. The Department accounts for Endowment for Children, Older Montanans Trust Fund and the Tobacco Settlement activity in this fund.

Fiduciary Fund Category

- ◆ **Agency Fund** – to account for resources held by the state in a custodial capacity. Agency funds may be used on a limited basis for internal clearing activity, but these must have a zero balance at fiscal year-end. The majority of the Department use of Agency Funds is for child support payments collected on behalf of children and distributed to custodial parents or guardians. Agency Funds also include money belonging to foster children and residents of care facilities.

2. General Fund Equity Balance

The negative fund equity balance in the General Fund does not indicate overspent appropriation authority. The Department has authority to pay obligations from the statewide General Fund within its appropriation limits. The Department expends cash or other assets from the statewide fund when it pays General Fund obligations. The Department's outstanding liabilities exceed the assets it has placed in the fund, resulting in negative ending General Fund equity balances for each of the fiscal years ended June 30, 2018 and June 30, 2019.

3. Direct Entries to Fund Equity

The Department recorded \$489,652,562 and \$499,896,185 of direct entries to fund equity in the General Fund during fiscal years 2018 and 2019 respectively. Most of the direct entries to fund equity in the General Fund result from entries generated by Statewide Accounting, Budgeting and Human Resources System (SABHRS) to reflect the flow of resources within individual funds shared by separate agencies.

Direct entries to fund equity in the State Special Revenue, Federal Special Revenue Fund, Capital Projects funds also include entries generated by Statewide Accounting, Budgeting and Human Resources System (SABHRS) to reflect the flow of resources within individual funds shared by separate agencies. Direct entries to fund equity in the General, State Special and Federal Special Revenue funds also include correction of errors from a previous period that occurred at least two fiscal years prior.

4. Nonbudgeted Activity

The Department's cost allocation plan for fiscal years 2018 and 2019 allocates shared costs across the divisions. Recognition of these costs distributions results in expenditure abatements (negative amounts) in the "Other Expenses" Operating expense account category of divisions that perform a significant amount of shared services.

5. Estimated Revenues & Transfers-In

Revenue estimates include an overstatement of \$29,327,370 in federal fund revenue for the fiscal year ended June 30, 2018. The majority of the overstatement is due to an incorrect revenue estimate for Medicaid. The revenue estimate was overstated due to the inclusion of prior year revenues when recording the estimate.

6. Operating Expenditures

Operating expenditures are \$47 million higher in the fiscal year ending June 30, 2019 than that of 2018. This is almost entirely due to Technology Services Division

expenditures related to expenditures for the Montana Program for Automating and Transforming Healthcare (MPATH). MPATH is a series of projects to implement modules and services to replace the State's aging Medicaid Management Information System (MMIS). Discrete modules are being obtained that support the Department's business needs, project guiding principles, and align with the CMS Final Rule for Mechanized Claims Processing and Information Retrieval Systems as described in 42 CFS 433.111.

7. Prior Year Activity

Prior Year Expenditures and Transfers-Out adjustments include the cancellation of unused expenditure liabilities estimated for Department benefit programs. The recognition of expenditures above estimated liabilities and standard prior year expenditure adjustments.

Report on Internal Control and Compliance

LEGISLATIVE AUDIT DIVISION

B-1

Angus Maciver, Legislative Auditor
Deborah F. Butler, Legal Counsel



Deputy Legislative Auditors:
Cindy Jorgenson
Joe Murray

REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL SCHEDULES PERFORMED IN ACCORDANCE WITH GOVERNMENT AUDITING STANDARDS

The Legislative Audit Committee
of the Montana State Legislature:

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to the financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the Schedules of Changes in Fund Equity & Property Held in Trust, Schedules of Total Revenues & Transfers-In, and Schedules of Total Expenditures & Transfers-Out of the Department of Public Health and Human Services for each of the fiscal years ended June 30, 2019, and 2018, and the related notes to the financial schedules, and have issued our report thereon dated January 21, 2020. Our report includes qualified opinions on each of the financial schedules for fiscal years ended June 30, 2019, and June 30, 2018.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial schedules, we considered the department's internal control over financial reporting to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinions on the financial schedules, but not for the purpose of expressing an opinion on the effectiveness of the department's internal control. Accordingly, we do not express an opinion on the effectiveness of the department's internal control.

Our consideration of internal control was for the limited purpose described in the preceding paragraph and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that were not identified. However, as described below, we identified certain deficiencies in internal control that we consider to be material weaknesses and significant deficiencies.

- ◆ As described in recommendation 1, the department's internal controls over federal Medicaid and Children's Health Insurance Program eligibility determinations are not designed to be effective.
- ◆ As described in Recommendation 8, the department does not have adequate internal controls to ensure transactions are processed in compliance with federal Supplemental Nutrition Assistance Program requirements.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial schedules will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit the attention by those charged with governance.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the department's financial schedules are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial schedule amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*. The identified instance of noncompliance is described below:

- ♦ As described in recommendation 1, a significant number of clients receiving benefits under the department's federal Medicaid and Children's Health Insurance programs may not meet the applicable eligibility criteria.

Department Response to Findings

The department's response to the findings identified in our audit are described on page C-1 of this report. The department's response was not subjected to the auditing procedures applied in the audit of the financial schedules and, accordingly, we express no opinion on it.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the department's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the department's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Respectfully submitted,

/s/ Cindy Jorgenson

Cindy Jorgenson, CPA
Deputy Legislative Auditor
Helena, MT

DEPARTMENT OF PUBLIC
HEALTH AND HUMAN
SERVICES

DEPARTMENT RESPONSE



Department of Public Health and Human Services

Director's Office ♦ PO Box 4210 ♦ Helena, MT 59620 ♦ (406) 444-5622 ♦ Fax: (406) 444-1970 ♦ www.dphhs.mt.gov

C-1

Steve Bullock, Governor

Sheila Hogan, Director

March 30, 2020

Angus Maciver
Legislative Auditor
Office of the Legislative Auditor
State Capitol, Room 160
Helena, Montana 59620-1705

RECEIVED
April 2, 2020
LEGISLATIVE AUDIT DIV.

Re: Financial Compliance audit

Dear Mr. Maciver:

The Department of Public Health and Human Services has reviewed the *Financial Compliance Audit* (19-14) completed by the Legislative Audit Division. Our responses and corrective action plans for each recommendation are provided below.

Recommendation #1:

We recommend the Department of Public Health and Human Services, as it relates to the Children's Health Insurance Program and Medicaid federal programs:

- A. Revise its Verification Plan to require additional information from the client when income information received from external data sources exceeds the limitation for the client's preliminarily authorized eligibility group, as required by federal regulations.
- B. Revise its policies and procedures, including any necessary revisions in the State Plan, to ensure only eligible individuals receive benefits, as required by federal regulations.
- C. Establish and maintain internal controls to timely verify client eligibility factors for all applicants and clients at application and redetermination.
- D. Comply with federal regulations and state plan requirements by placing only eligible clients into correct eligibility categories.

Response:

The department has established and maintained controls to timely verify client eligibility factors for applicants and clients at application and redetermination. Further, the department does comply with federal regulations and state plan requirements, placing eligible clients into the correct eligibility categories. The auditors chose to test member eligibility using standards that are 1) not approved, 2) not consistent with federal regulation, and 3) not permissible under federal law. The report discusses evaluating

member eligibility using data sources specifically prohibited by Montana statute during the period of the audit, and unallowable according to the federally-approved Montana Medicaid state plans. Finally, the auditors used an unapproved and limited data source to perform calculations specifically prohibited in federal law to reach their assertions of ineligibility.

The auditors claim ineligibility based primarily on a data source unavailable to the agency under state law, and impermissible according to federally-approved state plans. Pursuant to federal regulation, the State of Montana is mandated to follow its federally-approved state plans. Expecting the state to determine eligibility under an unapproved, unavailable rubric places the state at considerable risk of non-compliance with its federally-approved state plans.

The auditors “redetermined” eligibility based on auditor-designed calculations that do not comply with federal law and regulation. Medicaid law states that when using the Modified Adjusted Gross Income (MAGI)-based income methodology to determine eligibility, the financial eligibility must be based on the *current* monthly income and family size. Pursuant to regulatory requirements, income can and should be documented from many sources, not just tax return data.

The following are important components in understanding the underlying flaws in the audit methodology:

- The Social Security Act Section 1902 (e) 14 (H) states that an individual’s income must be determined at “the point in time at which an application for medical assistance... is processed...” Federal regulations require that MAGI-based financial eligibility for Medicaid “must be based on current monthly household income and family size.” (42 CFR 425.603 (h))
- Federal definition and direction are clear that MAGI-based calculations constitute a required methodology, not a number on a tax return. This is because tax return information does not represent an individual’s current income *at the time of determination*.

The auditors used state tax data to the exclusion of current evidence available in the member case files. This flawed approach is reinforced by implications in the audit report that increased use of a file that contains limited IRS tax data would result in improved eligibility determinations. These statements re-confirm that the auditors misunderstood the MAGI-based eligibility determination requirements established in the Social Security Act.

This resulted in an audit testing methodology that created a hypothetical standard of eligibility that does not comply with the Medicaid federal regulations.

The auditors used limited, unallowable information that is not current and impermissible methods to conclude that participants are ineligible. Montana has a legal obligation to provide health care coverage to citizens who meet the eligibility requirements of the legislatively approved Medicaid program. It would be unlawful for the department to deny or revoke health care coverage to Montanans who are eligible for the program as designed and approved.

Based on the flawed assumptions and approaches used in the underlying audit findings leading to these otherwise benign recommendations, the department does not concur.

Corrective Action: None.

Planned Completion Date: Not applicable.

Recommendation #2:

We recommend the Department of Public Health and Human Services conduct State Wage Information Collection Agency and Social Security Administration data matches to identify potential liable third parties at application for all Medicaid applicants, as required by the State of Montana Medicaid Plan.

Response:

The Montana Medicaid program uses many methods to identify the legal liability of third parties (TPL). The audit team appears to take issue with the timing of one of the methods used.

The department 1) uses the method in question and 2) uses it in accordance with a Verification Plan in compliance with 42 CFR 432.945 (j)

“(j) *Verification plan.* The agency must develop, and update as modified, and submit to the Secretary, upon request, a verification plan describing the verification policies and procedures adopted by the State agency to implement the provisions set forth in §§435.940 through 435.956 of this subpart in a format and manner prescribed by the Secretary.”

In addition to using the auditors' mentioned approach, please see the following discussion of preventive, detective and monitoring controls currently performed by department staff.

Preventive Control: Application Response

All applicants are asked at the time of application about existing health insurance coverage.

Preventive Control: SWICA and SSA Interfaces

- a) For non-MAGI applicants the interfaces are run prior to eligibility determination.
- b) For MAGI applicants the interfaces are run within 90 days of application through the post eligibility verification (PEV) process authorized by CMS via the Verification Plan. The department considers the PEV process an extension of application and eligibility determination, and has an approved plan with CMS to conduct these matches on the MAGI population as a part of that process.

Detective Controls: Other

Other resources used to identify liable third parties include the federal PARIS report, 8019 CHIMES reports with data from SSA, state buy-in reports (received from CMS), and information from Child Support Enforcement Division.

Monitoring Control: Trauma Questionnaires

Trauma questionnaires are issued to Medicaid members when claim details indicate the possibility of an accident that may be covered by a third party.

Monitoring Control: Health Insurance Premium Payment Program (HIPPS) Referral

When an individual is identified as having an employer - through any of the data sources available to the department - a HIPPS referral is generated and reviewed to determine potential cost avoidance opportunity.

The department has several methods of prevention, detection, and monitoring for third parties to ensure that Medicaid is the payor of last resort; therefore, does not concur.

Corrective Action: None.

Planned Completion Date: Not applicable.

Recommendation #3:

We recommend the Department of Public Health and Human Services:

- A. Establish and maintain internal controls to ensure Surveillance Utilization Review Section investigations for provider fraud are completely documented and retained.
- B. Implement changes in department policy and seek changes in legislation to remove restrictions on provider overpayment audits.

Response:

The department feels that an increased focus on new provider reviews offers the opportunity for proper education and training on allowable billing to establish best practices from the beginning of Medicaid service provision. Prior to auditor review, the department's own internal review of the SURS review plan identified an uneven ratio of new provider reviews in SFY 2018, and adjustments were made to ensure an appropriate cross-section of providers in subsequent reviews.

The department follows current state law with regards to records requests and allowable time frames. The statute that creates this criterion passed the 2017 Montana State Legislature with an overwhelming majority vote (49-0 in Senate; 94-2 in House). A bill reversing the limitations in the 2019 Montana State Legislature did not make it out of committee. The ultimate responsibility for changes in legislation lies with the Legislative Branch, not the department. The department cannot implement policy that conflicts with state law.

It would not be prudent for the department to commit to seeking changes in legislation when that activity is outside the control of the department. However, the auditors identified instances where record keeping activities could be strengthened. Therefore, the department partially concurs.

Corrective Action:

Strengthen internal controls regarding case file maintenance; re-train impacted staff on the documentation requirements.

Planned Completion Date: 06/30/2020

Recommendation #4:

We recommend the Department of Public Health and Human Services:

- A. Update policies and procedures for Medicaid beneficiary fraud investigations to require full investigations by department staff.

- B. Make referrals to law enforcement when there is reason to believe a beneficiary has defrauded the program, as required by federal regulations.

Response:

The department currently conducts investigations as required by federal regulations. Preliminary investigations are conducted on all referrals to the program integrity unit. If fraud or abuse is supported in available information, a full investigation is conducted. The auditors appear to take exception to time management guidelines included in desk level procedures. Those guidelines were removed in September 2019. The department makes referrals to law enforcement when, after the conclusion of a full investigation, there is reason to believe fraud has occurred.

The department already complies with federal regulations with regards to investigations of Medicaid fraud and referral to law enforcement. The recommendations are not necessary; therefore, the department does not concur.

Corrective Action: None.

Planned Completion Date: Not applicable.

Recommendation #5:

We recommend the Department of Public Health and Human Services:

- A. Develop a system to receive notification of individuals convicted of Medicaid fraud.
- B. Suspend individuals convicted of Medicaid fraud from receiving benefits for minimum time periods required by state law.

Response:

The department complies with applicable state law. Currently, however, there is no mechanism in place to notify the department of disqualifying convictions. Legislative action to create a system of reporting of convictions would be valuable in closing the gap between the Judiciary and the state Medicaid agency with regards to this matter. The department partially concurs.

Corrective Action:

Work with stakeholders in the Judiciary and in state and federal prosecution services to obtain a solution for providing this information to the department.

Planned Completion Date: 06/30/2021

Recommendation #6:

We recommend the Department of Public Health and Human Services:

- A. Establish and document internal controls to ensure all relevant contract disclosures and attachments are included in the Medicaid contract agreement prior to signature.
- B. Comply with federal regulations by including all applicable and required language in Medicaid contracts with non-federal entities.

Response:

The department has established and documented internal controls to ensure all relevant contract disclosures are conducted in a manner consistent with federal regulation. 2 CFR 180.300 allows for three options for verifying that entities the department intends to do business with are not excluded or disqualified from participation:

- (a) Checking SAM (System for Award Management) Exclusions; or,
- (b) Collecting a certification from that person; or
- (c) Adding a clause or condition to the covered transaction with that person

The required language related to debarment and suspension is communicated to entities the department intends to contract with through a variety of mechanisms; a full, formal contract is only one such mechanism.

The auditors appear to take exception with a specific mechanism: standard purchase orders. The purchase order (which is issued to vendors prior to the delivery of and payment for services) includes relevant disclosures and required language, and encompasses the covered transaction with the vendor. All purchase orders contain the following language:

The Contractor in agreeing to engage in the delivery of services in accordance with the Purchase Order to which this "Standard Terms and Conditions" document is attached and incorporated further agrees to acceptance of the Department's following terms and conditions and any other provisions stated in any other attachments to the Purchase Order.

Further, the "Standard Terms and Conditions" includes the following statement:

DEBARMENT: The Contractor certifies that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this Purchase Order by any governmental department or agency. If Contractor cannot certify this statement, attach a written explanation for review and consideration by the Department.

This information was provided to the auditors several times. However, the auditors concluded that this evidence is insufficient as it does not include a physical signature. The auditors did not identify an instance in which the federal requirements were not met.

The auditors' interpretation of what constitutes acceptance of contract terms and conditions is unnecessarily narrow; therefore, the department does not concur.

Corrective Action: None.

Planned Completion Date: Not applicable.

Recommendation #7:

We recommend the Department of Public Health and Human Services:

- A. Develop internal control procedures to ensure the appropriate funding source is used for its Health Insurance Premium Payment program.
- B. Use federal Children's Health Insurance Program funds to pay third-party health insurance premiums only for those individuals who qualify, as required by federal regulations.

Response:

Department controls were insufficient to ensure all charging mechanisms used in the health insurance premium payment program were accurate and updated as necessary. The department concurs.

Corrective Action:

Identify inappropriate costs charged to the Children's Health Insurance Program as a result of this finding and return the funds to the federal government. Develop control procedures to ensure that the HIPPS program maintains an accurate list of charging mechanisms and that impacted staff understand their use.

Planned Completion Date: 06/30/2020

Recommendation #8:

We recommend the Department of Public Health and Human Services:

- A. Obtain an annual SOC-1 Type 2 report over the electronic benefit processing service provider for Supplemental Nutrition Assistance Program, as required by federal regulations.

- B. Establish and maintain adequate internal controls to ensure Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families, and Special Supplemental Nutrition Program—Women, Infants and Children benefit transactions achieve applicable compliance requirements.

Response:

The department maintains that there are significant controls in place (and demonstrated to the auditors) to ensure Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families, and Special Supplemental Nutrition Program - WIC benefit transactions achieve applicable compliance requirements. The department only issues assistance to eligible Montanans based on the controls built within our eligibility process and system, our benefit issuance process and files, and benefit redemption process. The department fully reconciles the benefits issued to the amount of benefits placed on electronic benefit transfer (EBT) cards.

The department acknowledges that the SNAP federal guidelines are specific as to the requirements of independent audits of EBT service organizations and will be pursuing the appropriate level of audit beyond the annual SOC 2 Type 2 audit currently conducted. However, the department is not completely without controls in place to provide assurance over the operating effectiveness and appropriate design of controls at the service organization.

The department has established and maintained adequate internal controls, but has not required a SOC 1 Type 2 from its EBT vendor. Therefore, the department partially concurs with the recommendation.

Corrective Action:

Request a SOC 1 Type 2 audit be conducted and results submitted to the department from its EBT vendor. Include SOC 1 Type 2 audits in base requirements for all IT systems that provide financial processing services on behalf of the department. Include standard language regarding SOC reports in IT system contract templates.

Planned Completion Date: 09/30/2020

Recommendation #9:

We recommend the Department of Public Health and Human Services:

- A. Establish and maintain adequate internal controls to ensure reconciliations of Supplemental Nutrition Assistance Program benefits issued, redeemed, and unredeemed are conducted, as required by federal regulations.

- B. Conduct and document follow-up on differences identified in required reconciliations.

Response:

The auditors indicate that federal regulations require the department to reconcile all the benefits issued, redeemed and unredeemed each day, with the state's drawdown account. The federal oversight agency, USDA Food and Nutrition Service (FNS) has provided written clarifying guidance and indicates that reconciliation is a fundamental requirement of the electronic benefit transfer (EBT) system. The state should only verify on a detailed basis when discrepancies are found. FNS agrees that the basic functionality of reconciliation is tested extensively as a part of EBT system acceptance.

The following is guidance received by the department from FNS as it relates to 7 CFR 274.4 (a)(1):

Correctly logging transactions to the appropriate recipient accounts and retailers is the fundamental requirement of an EBT system. This basic functionality is tested extensively as part of system acceptance and is considered to be an EBT system function once the system is operational. However, system testing occurs in a relatively controlled environment. Testers have only a limited ability to create "unexpected" scenarios as part of their "what-if" testing. In addition, the extreme volume and high-speed processing of an EBT system brings many challenges related to system stress and capacity. Therefore, it can be expected that a certain amount of system errors will occur in an operational setting.

The intent of this regulatory citation is that the EBT system routinely performs this reconciliation. As an added control, the accuracy of transaction logging is verified annually as part of required SSAE-16 audits. Therefore, FNS does not expect State staff to perform this reconciliation on a daily basis for individual recipients. This reconciliation is required at a summary level as part of the overall EBT system reconciliation (7 CFR 274.4 (a)(1)(v)). The State would only need to perform this detailed reconciliation on an exception basis in the course of dispute resolution or in researching reconciliation discrepancies. States may opt to delegate this error resolution responsibility to their EBT processor, however, it may still be necessary for the State to intervene in some circumstances.

The auditors indicate that all the necessary reconciliations are not in place. However, the reconciliations not done by the state are done by the EBT contractor and available through reports generated in the EBT system. The statement that the reconciliations are incomplete

is incorrect. They are complete when considering both the service organization and the state processes. Obtaining the SOC 1 Type 2 report identified in the previous finding will provide the added control verifying the transaction logging.

The department conducts the necessary reconciliations required by FNS, but does not consistently document follow-up on identified discrepancies. Therefore, the department partially concurs.

Corrective Action:

The instances in which differences were noted by the auditors have been researched and documented. Internal controls regarding the documentation of follow-up activities conducted when discrepancies are identified have been updated and implemented.

Planned Completion Date: 12/31/2019

Recommendation #10:

We recommend the Department of Public Health and Human Services

- A. Work with the Department of Administration to properly update the Treasury State Agreement for benefit draws related to the Supplemental Nutrition Assistance Program.
- B. Comply with the Treasury State Agreement by completing the Supplemental Nutrition Assistance Program benefit draws from the federal government until such time as the Treasury State Agreement is revised.

Response:

The department maintains that controls are in place to assure that draws completed by the EBT service provider are done so appropriately by the contracted services organization. The administrative burden associated with transferring the SNAP benefit draws to the state is too significant to warrant shifting this function to department staff for the remainder of SFY 2020.

Due to the administrative burden of fully implementing the recommendation for SFY2020, the department partially concurs.

Corrective Action:

Work with the Department of Administration to update the 2021 TSA, which goes into effect July 1, 2020.

Planned Completion Date: 07/01/2020

Recommendation #11:

We recommend the Department of Public Health and Human Services enhance internal control and compliance with federal regulations for the Supplemental Nutrition Assistance Program by:

- A. Maintaining documentation to demonstrate consideration of the results of monthly Quality Assurance Division eligibility audits.
- B. Conducting and documenting training for staff completing eligibility determinations to address common errors, when identified by monthly Quality Assurance Division eligibility audits.
- C. Updating the Accounts Receivable Management System to automatically generate the beginning balances for the FNS-209 quarterly report, as required by federal regulations.
- D. Ensure the FNS-46 report is supported by accurate information via an audit of the EBT service organization or a documented monthly reconciliation.

Response:

The department does have controls in place to ensure that results of the quality control reviews performed in QAD are reviewed and acted upon by program staff. When the quality control (QC) unit identifies an error, the QC review and related documentation are uploaded to a shared document storage site. The SNAP Policy Specialist reviews the information and provides guidance and direction to the field as to what needs to be done to correct the errors. In addition, the QC summary reports are reviewed by the Human and Community Services Division senior management team to identify trends and determine appropriate program or system changes necessary to mitigate errors. These controls were provided to the auditors, and discussed at length. The department attributes the higher error rate to a backlog of work due to staffing shortages during the audit period, and is not a result of lack of training or not documenting training. The department conducts extensive new hire training and annual refresher training with eligibility staff. The department acknowledges that it is in a liability status with FNS regarding active case errors, and has been working extensively with the federal agency on corrective action. The department is also partnering on a business process re-engineering project with field, state, and federal representation aimed at reducing the SNAP error rate in Montana.

The department does not agree that updating the Accounts Receivable Management System (ARMS) to automatically generate beginning balances is required to complete the FNS-209. FPRS is the federal reporting system in which the department reports the FNS-209.

The federal reporting system (FPRS) generates the beginning balance for the FNS-209 from the ending balance of the previous report and is a locked field.

The department performs a daily reconciliation that meets federal requirements for the monthly FNS-46 report. As was communicated in the course of the audit, the department is ensuring the FNS-46 report is supported by accurate information through a daily reconciliation.

The recommendations do not address the underlying issues associated with the error rate, and are based (at least in part) on the federal SNAP error rate. The department is in an extensive corrective action plan directly with our federal partners aimed at addressing the core issues.

Further, creating an automated beginning balance in ARMS is unnecessary as it is not an editable field in FPRS for completing the federal report, and a monthly reconciliation is redundant and unnecessary. The department does not concur.

Corrective Action: None.

Planned Completion Date: Not applicable.

Recommendation #12:

We recommend, with respect to the Temporary Assistance for Needy Families program Income Eligibility and Verification System requirements, the Department of Public Health and Human Services:

- A. Develop and maintain internal controls to ensure staff follow-up when the file from the IRS is not received timely, and properly convert the file to a usable format upon receipt.
- B. Comply with federal regulations by comparing income information obtained from the Internal Revenue Service to information contained in the individual case records in order to determine the effect, if any, on individuals' eligibility or amount of assistance.

Response:

The department is in compliance with the federal requirements pertaining to the use of the Disclosure of Information to Federal, State and Local Agencies (DIFSLA) file received from the IRS. Specifically:

Sec 1137. [42 U.S.C.1320b-7] (a) (4) (C) states that the “use of such information shall be targeted to those uses which are most likely to be productive in identifying and preventing ineligibility and incorrect payments, and no State shall be required to use such information to verify the eligibility of all recipients”

Additionally, the final rule implementing changes to this program included changes to 45 CFR Part 205, which rescinded the requirement that a state must follow-up on all information received under the matching of its Income Eligibility Verification System. States are permitted to allocate resources to only follow-up on those items that are cost effective.

The department only receives the DIFSLA file twice per year. It is not a consistent source of information to use in making an eligibility decision, as the information included in the file is significantly dated. The file is limited to income such as dividends, interest and retirement income as reported on Forms 1099. When the file is received from the federal government, the department acts on it appropriately, reviewing cases against the IRS data in order to determine if more information is needed from clients as cases are worked. While the department is not in control of when or how often the IRS transmits the DIFSLA file, the department did add internal controls to reach out to the federal government when a file is not received as expected.

The recommendations are not necessary, as the department is compliant with the federal regulations with regard to the use of the DIFSLA file. Therefore, the department does not concur.

Corrective Action: None.

Planned Completion Date: Not applicable.

Recommendation #13:

We recommend the Department of Public Health and Human Services develop and maintain internal controls, in accordance with federal regulations, to ensure its tracking spreadsheet for recipients of extended Temporary Assistance for Needy Families benefits is complete.

Response:

The auditors identified weaknesses in internal controls related to tracking of extended benefits. The department concurs.

Corrective Action:

Update internal controls to ensure tracking spreadsheet for recipients of extended TANF benefits is complete. Train impacted staff on the changes to the control procedure.

Planned Completion Date: 06/30/2020

Recommendation #14:

We recommend the Department of Public Health and Human Services:

- A. Include only current cumulative expenditures in its federal Temporary Assistance for Needy Families quarterly reports.
- B. Develop and implement internal controls to ensure only expenditures incurred during the reporting period are included on federal Temporary Assistance for Needy Families quarterly reports.

Response:

The department has been completing the federal reports based on direction from federal partners that may not have been accurate. These recommendations will result in more efficient expenditure identification and reporting process for the department. The department concurs.

Corrective Action:

Revise federal reporting procedures to only include current cumulative expenditures when completing federal TANF reports. Revise federal reporting procedures to ensure only expenditures incurred during the reporting period are included on the federal TANF reports. Provide training on the updated control procedures to impacted staff.

Planned Completion Date: 04/30/2020

Recommendation #15:

We recommend the Department of Public Health and Human Services comply with state law and federal regulations by following state procurement policies to obtain services for one-on-one supervision of youth, chemical dependency evaluations, urine analyses, and support services for a child placed in the Foster Care program using Temporary Assistance for Needy Families funds.

Response:

The department complies with state procurement policies and federal regulations. State statute (Section 18-4-123(b), MCA) specifically excludes the provision of human services

administered by the department of health and human services from the state procurement policies. Further, these services are specifically exempt from the department's delegation agreement with the Department of Administration. The payments deemed inappropriate by the auditors were for direct services provided to clients being served through the department.

The disputed transactions are also not deficient when measured against federal regulations, which allow the department to micro-purchase services in small aggregate amounts. The department purchases services in the foster care program as separate and discrete transactions for specific clients in specific circumstances, and in most cases these purchases do not exceed the allowable aggregate limit. For larger amounts, federal regulations allow the department to use relatively simple and informal procurement methods for small purchases of services that do not cost more than the simplified acquisition threshold. Auditors chose to review expenditures based on provider total payment amounts, and not as discrete purchases by client, as is allowed under federal regulations.

The department complies with state procurement policies and federal regulations; therefore, does not concur.

Corrective Action: None.

Planned Completion Date: Not applicable.

Recommendation #16:

We recommend the Department of Public Health and Human Services:

- A. Establish and document internal controls to ensure required subrecipient disclosures are included in Foster Care contract agreements prior to signature.
- B. Comply with federal regulations by including required subrecipient disclosures in Foster Care contract agreements.

Response:

The auditors detected weakness in internal controls related to inclusion of disclosures for subrecipients in the Foster Care program. The department concurs; however, the recommendations seem duplicative.

Corrective Action:

Develop and implement internal controls relative to acquisition planning and implementation activities, to include a contract checklist reminding staff to include sub-recipient requirements in contract language, when applicable. Identify and amend existing

contracts that do not currently include subrecipient disclosures; communicate to impacted vendors.

Planned Completion Date: 10/31/2019

Recommendation #17:

We recommend the Department of Public Health and Human Services:

- A. Reimburse colleges and tribes only for activities allowed by federal regulation for the Foster Care program.
- B. Design and implement internal control to ensure detailed support for college and tribal invoices is obtained, reviewed, and approved prior to payment.

Response:

The auditors identified weaknesses in internal controls related to sufficient billing support and appropriate claiming of administrative staff in specific contracts with colleges and tribes. The department concurs.

Corrective Action:

Establish billing criteria for program participants to ensure that billing support provides appropriate evidence that only allowable activities are being reimbursed by the department. Update training plan to appropriately identify all training reimbursement proposals to ensure alignment with the federally approved plans. Adjust training budgets in impacted contracts to ensure that administrative staff are appropriately claimed.

Planned Completion Date: 06/30/2020

Recommendation #18:

We recommend the Department of Public Health and Human Services design and implement internal control to ensure child support recoveries are properly reported on its Foster Care CB-496 reports.

Response:

The department has internal controls to ensure that required information is included in the Foster Care CB-496 reports. The controls were insufficient to identify possible omissions when the 5% variance threshold was not reached. The department concurs.

Corrective Action:

Strengthen internal controls to ensure that omissions are detected, even when below the allowable 5% variance threshold. Correct all impacted CB-496 prior submissions.

Planned Completion Date: 12/31/2019

Recommendation #19:

We recommend the Department of Public Health and Human Services:

- A. Develop internal controls to document the obligation of all funding types for the Child Care Development Fund federal award.
- B. Ensure obligation for Mandatory, Discretionary, and Matching funds for federal Child Care Development Fund awards occurs within the timelines required in federal regulation.

Response:

The condition of non-compliance for this finding does not exist. The department follows documented controls for obligation of funds via the ACF 696 report. The obligation of child care funds is further supported by documented historical data which informs completion of the ACF 696 obligations. The ACF 696 report has consistently demonstrated obligation of CCDF funds supported by historical data and certificate obligations. If the report had not been done correctly, the federal matching funds would not have been released. The department has established internal controls to ensure obligation of Mandatory, Discretionary and Matching funds for the federal Child Care Development Fund occur within the timelines required in federal regulation.

The department complies with the federal regulations associated with the CCDF funds; therefore, does not concur.

Corrective Action: None.

Planned Completion Date: Not applicable.

Recommendation #20:

We recommend the Department of Public Health and Human Services:

- A. Ensure all health and safety standards are considered in its reviews of day-care facilities for the Child Care Development Fund program, as required by federal regulation.
- B. Enhance internal control for the Child Care Development Fund program by updating its day-care monitoring form to ensure all health and safety elements are included.

Response:

The department conducts thorough health and safety inspections of day-care facilities. The auditors identified weaknesses in internal controls resulting in administrative rules and checklists not being updated timely with changes in federal regulation. The department concurs.

Corrective Action:

Update administrative rules associated with reviews of day-care facilities to ensure all required elements are included. Update checklists used in reviews of day-care facilities to ensure all required elements are not only checked, but documented in the review record.

Planned Completion Date: 06/30/2020

Recommendation #21:

We recommend the Department of Public Health and Human Services:

- A. Develop internal control procedures for the Child Care Development Fund program to confirm letters have been sent and collections initiated when required for fraud cases.
- B. Comply with federal regulations by seeking timely recovery of all identified fraudulent child care overpayments for the Child Care Development Fund program.

Response:

The department did not have internal controls in place to ensure these activities continued during staffing shortages. The department concurs.

Corrective Action:

Update internal control procedures and hire a collections specialist to confirm letters have been sent and collections initiated.

Planned Completion Date: 12/1/2019

Recommendation #22:

We recommend the Department of Public Health and Human Services:

- A. Conduct and document a review of all cost pools to ensure department procedures align with the approved cost allocation plan.
- B. Implement changes to the cost allocation process only after receiving approval from, or submitting a plan revision to, the federal government.
- C. Develop and implement internal control to detect variances in cost pools based on a full-time equivalent staff statistic.

- D. Allocate costs as specified in the cost allocation pool, as required by federal regulations.

Response:

The department has established controls to ensure that cost pools are allocated according to the cost allocation plan. Cost pools are tested monthly to include reviews of variance, completeness and statistics results, which provide additional oversight of cost pools and their allocation methodology. Additionally, the department reviews the cost pools as a part of the cost allocation plan submission.

These controls were insufficient to detect variance in cost pools with a full-time equivalent (FTE) directly-supervised statistic. While the department agrees that the FTE-based statistic cost pools exhibited errors in allocation, the department does not agree that the County Use Allowance and Reimbursement Travel indirect cost pools are in error. The auditors note that charges were made prior to submitting a revised allocation plan. However, the allocation plan submitted served only to provide additional clarity around costs previously summarized in more general cost pools.

The department only implements changes to the cost allocation process after submitting plan revisions to the federal government, as is allowable. It is not always feasible to receive approval for cost allocation plans prior to claiming costs related to modified or amended cost pools. The department may request an earlier or later date of a cost allocation plan amendment per 45 CFR 95.515 in order to avoid a significant inequity to either the State or Federal government.

The department does not agree with the underlying findings related to two costs pools; therefore, the department partially concurs.

Corrective Action:

Implement internal controls to detect variances in cost pools based on a full-time equivalent staff statistic. Institute a review of cost pools to ensure costs are allocated as specified in the plan.

Planned Completion Date: 12/1/2019

Recommendation #23:

We recommend the Department of Public Health and Human Services:

- A. Develop internal review processes to ensure staff apply the clearance pattern approved in the Treasury State Agreement for Low-Income Home Energy Assistance program cash draws.
- B. Comply with the requirements of the Treasury State Agreement by drawing federal funds for Low-Income Home Energy Assistance program warrants on a five-day clearance pattern.

Response:

The department has an internal review process which detected the clearance pattern error, as is the control process design. Department staff communicated the clearance pattern error to the auditor during the course of the audit, but not as a deficiency. Because the control procedure worked as designed, the error was detected, the internal draw spreadsheet was corrected and the draw rectified.

The internal control procedure currently in place operated as designed, allowing for the detection and correction of errors. The department does not concur.

Corrective Action: None.

Planned Completion Date: Not applicable.

Recommendation #24:

We recommend the Department of Public Health and Human Services:

- A. Modify procedures for federal cash draws for the Supplemental Nutrition Program for Women, Infants and Children, to eliminate instances of excess federal cash, as required by federal regulations.
- B. Modify the calculation for federal cash draws for the Child Support Enforcement program to take into consideration anticipated cash collections from non-federal sources, and to eliminate instances of excess federal cash, as required by federal regulations.
- C. Comply with federal regulations to minimize the time between the drawdown of cash for the federal Supplemental Nutrition Program for Women, Infants, and Children and Child Support Enforcement programs and disbursement for federal program purposes.

Response:

The department has documented controls in place to minimize federal cash on hand. Because collections from non-federal sources can fluctuate, the department may not be

able to fully estimate collections from non-federal sources to eliminate excess cash in certain instances. Therefore, the department partially concurs.

Corrective Action:

Additional controls are being researched to

- determine if the department can modify draws to incorporate rebates received for the Supplemental Nutrition Program for Women, Infants and Children
- determine if the department can modify draws to incorporate cash collections from non-federal sources to reduce instances of excess federal cash.

Planned Completion Date: 04/30/2020

Recommendation #25:

We recommend the Department of Public Health and Human Services initiate federal cash draws for the Foster Care and Child Care Development Fund programs in accordance with department policy.

Response:

The department has reviewed supporting documentation for grant funds available for draw for the foster care program and determined projections were insufficient to allow the department to draw adequate funds to support expenses. The department concurs.

Corrective Action:

Modify foster care benefit projection model to identify potential future instances of negative cash to ensure fund requests are sufficient to support anticipated expenditures. Modify the federal cash draw sheets for the Child Care Development fund to appropriately draw funds and reduce instances of negative cash.

Planned Completion Date: 03/01/2020

Recommendation #26:

We recommend the Department of Public Health and Human Services establish and maintain internal controls to ensure Automated Data Processing system reviews are completed and fully documented on a biennial basis, as required by federal regulations.

Response:

The department agrees that the review of two of 80 systems was not completed in the required timeframe. These reviews were completed prior to the completion of this audit (11/8/2019 and 11/26/2019). The department concurs.

Corrective Action:

Adopt and implement the Department of Administration tracking tool developed to ensure that all required reviews are identified and conducted as required by federal regulations.

Planned Completion Date: 06/30/2020

Recommendation #27:

We recommend the Department of Public Health and Human Services:

- A. Conduct and document a thorough review of Construction Work in Process balances for all fund types, and make corrections to the state accounting records as appropriate.
- B. Develop and implement internal controls to ensure Construction Work in Process balances are properly removed from the state's accounting records when assets are capitalized, in accordance with state accounting policy.

Response:

The internal controls associated with this process relied on queries in the asset management (AM) module within state accounting system. The AM queries show that these specific assets are marked as In Service in the AM module, which is correct. The department has incorrectly relied on the accuracy of this categorization and assumed it carried through to other ledgers within SABHRS. When running independent checks of the account codes relative to CWIP, the department has been looking at them in isolation to one SFY, which is insufficient to detect improper accounting treatments. The department concurs.

Corrective Action:

Update internal controls to include additional controls that query appropriate accounts in all affected accounting ledgers in the statewide accounting system to ensure correct categorization and accounting treatment of CWIP. Develop a questionnaire requesting program input on CWIP to assist in proper fiscal year end procedures. Work with the Department of Administration to complete required corrections in the accounting records.

Planned Completion Date: 04/30/2020

If you have any questions regarding our response, please contact Erica Johnston, Operations Services Branch Manager, at (406) 444-9773.

Sincerely,



Sheila Hogan, Director
Department of Public Health and Human Services

cc:

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Stuart Fuller, Technology Services Division Administrator
Rebecca de Camara, Developmental Services Division Administrator
Darcy Wiebe, Health Resources Division Administrator
Barb Smith, Senior and Long-term Care Division Administrator
Jamie Palagi, Early Childhood and Family Services Division Administrator
Zoe Barnard, Addictive and Mental Disorders Division Administrator
Chad Hultin, Audit Liaison
James Fehr, Human Resources Director
Peter Bovingdon, Chief Legal Counsel